PUBLIC HEALTH NURSING

NOVEMBER
1946

Breakfast and the Daily Protein Need

The significance of breakfast in the satisfaction of nutritional requirements has been emphasized in many quarters in the recent past. Breakfast serves to replenish many nutrient stores depleted during the long fast from the previous evening meal, and provides the organism with caloric food energy needed for maximum efficiency during the morning hours. Hence nutrition authorities advise that breakfast should supply from one-fourth to one-third of the daily caloric and nutrient needs.

The morning meal should provide, among other things, its share of the daily protein requirement, since the protein needs must be met daily for proper growth of children and for good nutritional health of adults. In a basic breakfast so widely recommended—fruit, cereal, milk, bread and butter—the protein contribution is significantly high—20.7 Gm., or about 29 per cent of the adult requirement. Not a small amount of this protein is provided by the average serving of cereal (ready to eat or to be cooked), milk and sugar—fully 10 per cent of the adult daily protein need. Thus an important protein contribution is made by the basic breakfast, of which cereals are an integral and universally recommended component.

This average cereal serving also provides B complex vitamins, caloric food energy, and important minerals. Its mixture of proteins is of high biologic value, applicable for the satisfaction of growth and maintenance requirements. Note from the table of composite averages the contribution made by the cereal serving—1 ounce of cereal (whole grain, enriched, or restored to whole-grain values of thiamine, niacin, and iron), 4 ounces of milk, and 1 teaspoonful of sugar—and by the basic breakfast.

	Nutrition Composition of The Basic Breakfast*	Average represented by: cereal, 1 oz.; whole milk, 4 oz.; sugar, 1 teaspoonful
Calories	611	202
Protein	20.7 Gm.	7.1 Gm.
Fat	19.0 Gm.	5.0 Gm.
Carbohydrate	89.4 Gm.	33.0 Gm.
Calcium	0.465 Gm.	0.156 Gm.
Iron	3.0 mg.	1.6 mg.
Vitamin A	1074 I.U.	193 I.U.
Thiamine	0.52 mg.	0.17 mg.
Riboflavin	0.87 mg.	0.24 mg.
Niacin	2.3 mg.	1.4 mg.
Ascorbic Acid	64.8 mg.	

*Orange juice, 4 oz.; cereal, 1 oz.; milk, 4 oz.; sugar, 1 tsp.; bread (enriched, white), 2 slices; butter, 1 tsp. (5 Gm.); milk, 8 oz.

The presence of this seal indicates that all nutritional statements in this advertisement have been found acceptable by the Council on Foods and Nutrition of the American Medical Association.

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CONTENTS

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PUBLIC HEALTH NURSING

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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine PUBLIC HEALTH NURSING; and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity. The acceptance of any of its recommendations is entirely voluntary.

Membership—Nurse, $3; General, $3; Sustaining, $10; Life, $100. Agency—Full dues 1% of annual expenditures for public health nursing service. Associate agency, $10.

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INGREDIENTS

Whole Wheat Meal • Corn Meal • Wheat Germ • Malt • Non-fat Dry Milk Solids • Calcium Phosphate • Dried Brewers' Yeast • Salt • Iron Ammonium Citrate.

TYPICAL ANALYSIS

Carbohydrate 73.1%
Protein (Nx6.25) 15.0%
Fat (ether extract) .8%
Ash (total minerals) 3.8%
Crude Fiber 1.6%
Calcium (Ca) 800 mg. per 100 gms.
Phosphorus (P) 580 mg. per 100 gms.
Iron (Fe) 30 mg. per 100 gms.
Copper (Cu) 2 mg. per 100 gms.
Thiamine (B_1) 1.0 mg. per 100 gms.
Riboflavin (B_2) 0.3 mg. per 100 gms.
Moisture 5.7%
Calories per ounce 102.

NUTRITIONAL VALUES

While the quantity of Clapp's Instant Cereal used may vary considerably for the individual, ½-oz. and 1-oz. quantities may be considered average daily amounts for the infant and young child respectively. These amounts furnish the following percentages of the minimum daily requirements:

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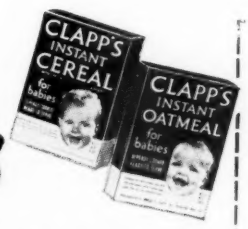

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You, in your nursing practice, encounter many such patients, from the neurotic to the person on the verge of mental disorder. It is of utmost importance that you understand as much as possible the background of these problems so that you will not do harm by ill-advised words or actions.

We have several books of proven worth to offer you, books that are exceptionally enlightening. A HANDBOOK OF ELEMENTARY PSYCHOBIOLOGY AND PSYCHIATRY by Dr. Billings outlines the problems involved in disorders of personality functioning. It is small enough to be carried around in your purse. PSYCHOTHERAPY IN MEDICAL PRACTICE by Dr. Maurice Levine is written for general practice. It gives real insight in the problems that are encountered by you, too, in your daily practice, and will enable you to cooperate with the physician in the management of minor mental disturbances. Public Health Problem No. 4—Alcoholism—is treated in ALCOHOL, ONE MAN'S MEAT by Dr. Strecker and Francis Chambers. The collaborators, extremely successful in treating chronic alcoholics, here describe motives of drinking and methods of rehabilitation. They also point to the danger signals of potential alcoholism. You can do much in helping prevent this socially ruinous disease.

To help your patients understand themselves (which is the first step toward improvement) we recommend two books written for the layman. DISCOVERING OURSELVES: *A View of the Human Mind and How It Works*, by Drs. Strecker and Appel, explores the human emotions, and their devious ways of expressing themselves in our everyday behavior. It points to the *danger signals* that show when a natural tendency may turn into abnormal behavior. If your patients have symptoms that cannot be explained by organic causes, MANAGING YOUR MIND: *You Can Change Human Nature*, will help them understand their condition, and show them what to do about it. Written by Dr. Kraines and E. S. Thetford, it is such fascinating reading that it has a large public who find it good medicine against many "aches of civilization."

MACMILLAN

Sixty Fifth Ave., New York 11

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

NOPHN Resolves—

THE FUTURE to which we have looked forward hopefully for so long is here. This is the time to put into action the plans we believe essential for progress. The cry is repeated from all sections of the country for more qualified public health nurses in all types of services. To answer this need, more not less effort, more not less determination to plan thoughtfully, and more not less attention to standards are required. We cannot wait until we are ready to give perfect public health nursing service, for service is needed now by all the people.

Public health nurses are noted for their ability to recognize and accept responsibilities and to adjust to difficulties. We take pride that public health nurses are actively serving humanity in these difficult days when there is a need for understanding service and sincere willingness to help solve some of the world's most serious problems.

In this spirit, the National Organization for Public Health Nursing, in its Twentieth Convention, adopts the following resolutions as evidence of the responsibilities public health nurses are ready to assume in carrying out the nation's health plans. It has been reiterated frequently that each NOPHN member can best do her part to make our resolutions effective as she puts them into action in her own small sphere of influence.

I. WHEREAS, the activities of the National Organization during the last biennium were carried on during the last year of war and the first year of peace with their tremendous problems of adjustment, and the membership has truly appreciated the ever dependable and dynamic leadership of the retiring president, Marion W. Sheahan, who in addition to other many and varied demands on her time, has given so generously of herself and her wisdom to our service,

THEREFORE, we tender Miss Sheahan our sincere and heartfelt thanks. We also thank Ruth Houlton, NOPHN general director, for her untiring efforts and for the ever increasing wisdom and judgment which she has brought to the organization. To the members of the professional staff of the NOPHN for carrying on under many difficulties and to the business staff for their efficient service, we extend our thanks and appreciation.

II. WHEREAS, in the period since our last convention we have suffered a serious loss in the death of one of our members, Grace L. Anderson, and since in the loss of Miss Anderson, nursing has been deprived of a stimulating leader and nurses throughout the country have lost a friend, guide and mentor, be it therefore

RESOLVED, the NOPHN wishes this expression of its affection and appreciation to be spread upon the records of the organization and sent to Miss Anderson's family and to her long time associate, Mabelle S. Welsh.

III. WHEREAS, it is appreciated that the planning and management of a large convention are arduous and time-consuming tasks, be it therefore

RESOLVED, we the members of the NOPHN thank all who made this meeting a success—New Jersey State Nurses' Association, New Jersey League of Nursing Education, New Jersey State Organization for Public Health Nursing, State Arrangements Committee, all the subcommittees and student monitors, Convention Bureau, exhibitors, and the staff of the Convention Hall. We thank all the agencies who made it possible in spite of difficulties, to send representatives to this meeting and we heartily thank all those who presented papers and reports. We extend

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This report of the Resolutions Committee was adopted at the closing business session of the National Organization for Public Health Nursing, Biennial Convention, Atlantic City, New Jersey, September 27, 1946.

appreciation and thanks to the hotels which provided accommodations for all our members without discrimination on the basis of race or creed.

IV. WHEREAS, the theme of this convention is "Nursing in the Nation's Plan for Health," and the greatest need in this postwar period is the wisdom and capacity to bring the benefits of science to all the people, and since public health nurses are among the professional groups who can do much toward translating these benefits into action, be it therefore

RESOLVED, that NOPHN express its belief

1. That a program of activities for optimum health, in which it has been demonstrated that qualified professional public health nurses contribute vital and essential service, should be made available to all peoples of the United States, and

2. That national governmental and voluntary agency planning for the establishment of needed facilities and the selection and preparation of qualified personnel be related to this program, and

3. That the program be made more effective by the greater coordination of activities of governmental and voluntary health agencies at the federal, state and local levels.

V. WHEREAS, a committee representing national and federal agencies concerned with public health nursing has recommended and published in PUBLIC HEALTH NURSING, August 1946, "Desirable Organization of Public Health Nursing for Family Service" in a local community, and the principles recorded in this statement are basic to planning such a service, be it therefore

RESOLVED, that the members of NOPHN endorse this statement and

1. That they urge the public health nursing field consultants of all national governmental and voluntary organizations to seek opportunities to put the expressed principles into practice through field visits and

2. That the NOPHN ask the directors of university programs of public health nursing to give particular emphasis to the principles expressed in this statement in the preparation of public health nurses.

VI. WHEREAS, the care given to mothers and children is an index of the degree of civilization any society has achieved; and the care available to mothers and children in the United States is inadequate in quantity and quality; and personnel qualified to give a high degree of care is lacking in many areas; and much of the program that can be measured in terms of reduced mortality has been the result of detecting, treating, and curing pathology, be it therefore

RESOLVED, that there is a great need for development of highly qualified personnel to work with *normal* mothers and children, and that courses in advanced maternity nursing should be established for the further preparation of nurses to enable them to provide the necessary leadership to develop, in cooperation with other professional groups, service which goes beyond the detection and prevention of pathology and has as its goal abundant health for all mothers and their offspring.

VII. WHEREAS, there is increased interest in the health of the school age child, and recognition of the lack of adequate health services for this age group, and countrywide recognition that education, health, and other community agencies must plan together for complete school health programs, be it therefore

RESOLVED, that NOPHN exert its efforts toward promoting joint planning at national, state, and local levels among the many groups interested in the health of the school age child, in order that more effective programs may result.

VIII. WHEREAS, almost one-half of the workers in the United States are employed in plants with 250 or fewer workers and few of these plants have any in-plant health service, be it therefore

RESOLVED, that NOPHN continue its program of assistance to agencies providing part-time health service in small industrial establishments and seek every means to extend further service to these agencies.

IX. WHEREAS, consideration of the problems of long-term illness, including psychiatric disorders, is now rightfully being included in public health programs and as such demanding the attention of public health nursing; and personnel qualified to give adequate care are lacking in many areas, be it therefore

RESOLVED, that NOPHN reemphasize its interest in this program and provide assistance to agencies in working out the best methods

of providing adequate nursing care for this group.

X. WHEREAS, the statement of need for cooperative planning for adequate health services for all groups and the statements of need in regard to the specialized public health nursing services emphasize the lack of qualified personnel and facilities and the lack of means to bring medical and public health services within the reach of all, be it therefore

RESOLVED, that NOPHN restate its belief that prepayment health insurance plans must be expanded and, that nursing should be included in all such plans whether compulsory or voluntary, and that in addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services.

XI. WHEREAS, the NOPHN Committee on Personnel Policies has published forward-looking recommendations for adequate personnel policies, including salary policies, and these are greatly needed at this time by all agencies employing public health nurses; and nurses are today facing the problem of how best to bring about the establishment of adequate personnel policies; and

WHEREAS, the Structure Study report recommends one method of organization for nurses to provide for collective bargaining and this report requires further study, be it therefore

RESOLVED, that NOPHN express its belief that until this or some other recommendation is accepted, all discussions and negotiations for improvement of personnel policies should be carried on through professional nursing organizations rather than through organized unions, and be it further

RESOLVED, that professional nursing organizations assume aggressive responsibility for a public relations program which will inform the public of the scope of activities and problems of public health nursing, and be it finally

RESOLVED, that professional nursing organizations use their influence to equalize opportunities for employment and secure equal salaries for *all* public health nurses solely on basis of their qualifications without discrimination as to race or creed.

XII. WHEREAS, provision for economic security is a basic need for all groups and the federal plan to provide financial assistance when people reach retirement age is now in effect for many but not all groups of the population, be it therefore

RESOLVED, that NOPHN favor the extension of the old age benefits of the Social Security Act to include participation of all nurses.

RESOLUTIONS COMMITTEE
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ANNA M. FILLMORE, R.N.
HELEN L. FISK, R.N.
RUTH REEVES, R.N.
MRS. S. EMLEN STOKES
MARIAN G. RANDALL, R.N., Chairman

The Work of the NOPHN Must Go On!

By MARION W. SHEAHAN, R.N.

THIS MEETING is a crucial one in the history of nursing organization. We shall be called upon to consider our structure in relation to other organizations for nursing. Before too many months, this organization must reach a decision concerning the recommendations for an organizational structure in the interest of carrying out the objectives for *nursing* and our specific objectives for furthering the health of the people through the extension of public health nursing. We shall be expected to review our organization objectives and loyalties with the larger goals in mind. The result of our decisions here will influence our chosen field of responsibility for many years to come. Our work must go on whatever changes may be made in the structure through which we work.

The obligation assumed by the NOPHN in its 34 years of existence gives conclusive evidence that it now can face the more grim obligations which are known to lie ahead. We were organized:

To stimulate responsibility for the health of the community by furthering the establishment and extension of Public Health Nursing, and the education of nurses in Public Health;

To develop standards and technics in public health nursing;

To facilitate efficient cooperation between nurses and health officials, physicians, boards of trustees, other agencies and persons interested in Public Health;

To establish and maintain a central bureau for information, reference and assistance in matters pertaining to public health nursing;

To publish periodicals and to issue bulletins from time to time to aid in the accomplishment of the general purpose of this Organization.

In order that we may gain confidence and the courage which come with the knowledge of a job well done it will do no harm to examine the record of accomplishment toward these avowed objectives.

The NOPHN is recognized as the professional standard making body for public health nursing. Educators, administrators, nurses, officials of government and those consumers "in the know" base their judgments in this field on the statements, qualifications, functions, and principles and procedures which have been drafted and kept abreast of current practice through periodic review.

It has found its influence reaching into federal and state government, in health and civil service fields, and in the final analysis through the doorways of the homes of the land.

For all these years, the organization has been the instrument to keep actively exercised those channels which assure professional progress: discussion; conferences, committee activities, and published material, through which media leadership is exerted for public health nursing. When you read the published NOPHN Biennial Report, note the number of different individuals who contributed their time, their interest, and the product of their thinking processes. Study the names of committee members. Note the scope of interest represented and the geographical spread of representation. They represent the activities which may exist in any community where there exists a public health nursing agency.

Consider the methods which have been developed. They combine the work of the staff at national headquarters in conjunction with the work of a large number of members and co-workers of the organization who, through round-table discussion, pool their judgments.

Miss Sheahan, president of NOPHN from 1944 to 1946, gave this address on the purposes and accomplishments of the National Organization, at the opening business meeting, Biennial Convention, Atlantic City, September 23, 1946.

These judgments define concrete problems, outline plans for attack, and the methods to reach a solution. Definitions are reached as to standards for personnel, for program content, for organization and administration, record keeping, et cetera. The procedure whereby a staff member serves as secretary to follow through the decisions of the committee is extremely effective in getting the job done.

As you read the reports, think of the fine abilities exerted by the staff at headquarters who give positive leadership to committee activities and at the same time follow the leadership of committees through the acceptance of the pooled judgment—truly a democratic performance.

As you read, think that we who stay at home in a community job, whether it be paid or voluntary, have had our opinions expressed via this effective method of democratic organization.

This collective thinking helps some agency in need whenever a report is published or a member of the staff visits in the east, the west, the north, or south. The agency is a center of information, reference, and assistance in matters pertaining to public health nursing. The magazine PUBLIC HEALTH NURSING and other publications are a recognized aid to accomplish the purpose of this organization.

It must be remembered that the volume of work depends upon the volume of members who in turn determine the extent of influence of an organization such as ours. Let us hope the membership rally will draw in a large number of nurses and non-nurses who, if members, would add a tremendous force to do the job which lies ahead.

WHAT ARE the immediate and urgent needs to keep public health nursing apace with the spectacular race in the program for better health? The Hill-Burton bill, the Pepper bill, the Wagner-Murray-Dingell bill, the efforts toward health legislation in various states, the assured expansion of health services for tuberculosis, crippled children, mental disease, cardiacs, are all expressions of society's interest in its own health. The frenzied activity toward health improvement through so many legislative bills in due time will, no doubt, reach more normal production. Nonetheless, such activity is a convincing expression of the judgment of the people that better health organization must be provided for the nation as a whole. The needs are recognized, the methods for distribution and support are still subjects for debate.

There is reasonably close agreement that every suitable unit of population should have a health department with a qualified health officer with a good program for health protection, an adequate staff with adequate equipment, and adequate budget. There is, also, reasonably close agreement that such a basic health organization is the responsibility of government which is an administrative expression of what "we the people" want assured for our protection, and agreement that all other efforts of voluntary nature are supplementary thereto.

The USPHS and the APHA have defined a standard for local health units for every area of the country. The proposal is a health unit of not less than 50,000 people and one nurse to every 5000 population within an accessible radius to the center. This recommendation is based on a health program limited to the nursing service essential for the irreducible minimum of six basic services—Vital Statistics, Environmental Sanitation, Control of Communicable Disease, Laboratory, Public Health Education and Maternity, Infancy and Child Hygiene including supervision of the health of the school child.

The NOPHN has given consideration to the inadequacy of such a standard for public health nursing. Voluntary agencies defined public health nursing as stemming from curative or visiting nursing long before health departments assumed appreciable responsibility for a health program as it is conceived today. Now the question is to be answered, "Is the most effective public health nursing for the family an integrated service where the prevention of disease and health promotion are the objectives of the nursing service, with sickness care provided if illness is present; *or* is the extent of the official program the former without nursing care during illness?" The answer is to be based on a realistic consideration of historical development of nursing as a community service provided by both voluntary and official agencies; on public economy in these days of mounting

government costs; and on the possibilities for accomplishment of goals set in the various areas of the country.

Under the aegis of the NOPHN, this question was studied with resulting recommendations for "a desirable organization for public health nursing." These recommendations were reached through committee of representatives of those national and federal agencies whose influence or programs influenced local service. The report of this committee is published in the August PUBLIC HEALTH NURSING. That report should be studied, not just read.

If we are to stimulate responsibility for the health of the community by furthering the establishment and extension of public health nursing,—part of our first objective—then through all means in our power, we must keep at the job of bringing about the standard which we have helped to develop. It can fit into the proposed organization for the larger structure which is public health in its broadest sense.

THE POSTWAR NURSING needs of the country are expressed neatly in the recent report of the Michigan Council on Community Nursing which establishes a general principle of nursing coverage for the health of the citizens of Michigan. "Such coverage," the report states, "should include prevention of illness, maintenance of vigorous health, not feeble organic functioning, and remedial aspects of nursing when illness occurs. This pyramidal concept of nursing in relation to health and well-being of its citizens must be planned for all the people of the state. . . . This is clearly not the work of nurses alone, but also of doctors, health educators, public school teachers, the radio, the university, the press, and citizen groups acting as leaders and exemplars. It must be said at once that it will be impossible to consider nursing apart from the other forces in the social configuration when mapping out the needs of any area, large or small."

I would commend the Report of the Michigan Council on Community Nursing as a splendid expression of group thinking sharpened to the point of concise written analysis of needs and recommendations for constructive action.

Seen in relation to a locality, the Michigan principle for nursing coverage crystallizes the direction which we have been taking for some time toward a broadening of our concept of our first objective "furthering the health of the nation through the extension of public health nursing and the education of nurses for public health."

Now, in many communities two or more nurses with public health training go into the same home each including public health nursing and basic nursing skills in their services. Is it not sensible to review our leadership proclamations concerning required personnel and qualifications in the light of our recommendation that in a desirable organization "each public health nurse in her home visits combine the multiple functions of health teaching, prevention and control of disease, and care of the sick?"

Is it within the realm of reason to think that enough nurses could be prepared for this huge potential expansion? The demand now is far ahead of the supply. Our standards for public health nursing need immediate testing to determine whether one public health nurse for 5000 would be adequate if she had as an assistant a registered professional nurse and a practical nurse for the visits where nursing care is the service rendered. The methods of administration, the contribution of each grade of nurse and other guides should be forthcoming within the near future. Old standards must now be proved if they are to remain as standards or they should be revised.

THIS NEED for research to give immediate administrative direction has been called urgent by our Committee on Administrative Practice. Money has not been secured as yet to conduct comprehensive pilot studies. If each of us in our own situations expresses the needs, this organization may be able soon to study and provide answers to:

1. What is the full impact on nursing of a complete program for community health? (Continuity of patient care and health instruction following a period in hospitals, in nursing or maternity homes and mental institutions. Adequate nursing care and health instruction for welfare clients inclusive of foster home children and home care of chronics are examples of known needs about which little has been done.)

(Continued on page 620)

". . . It is a tree of life."

By RUTH WEAVER HUBBARD, R.N.

AT THIS MOMENT I sincerely join with Miss Sheahan, our retiring President, in the wish that it were possible to announce today the successful election of all the candidates who were nominated. By such a device we could insure to this organization the leadership it so richly deserves.

Some twenty-five years ago my first supervisor led me on my first home visit. It was a cold February day and we were near the shore of the Atlantic Ocean. I felt then that I could never be more frightened in my life. I know now that I was wrong. Today, as I stand again near the shore of the great Atlantic Ocean, before you who have asked me to carry a new part in our NOPHN, I am far more frightened than on that distant first visit to my first patient. As my supervisor guided me then, so I ask you now to give me always your guidance, your criticism, your support, remembering that it is not I who am an officer, but we who are the NOPHN—staff, board, and membership—who have the opportunity and therefore the responsibility to make our contribution as public health nurses in a world that has needed us never as much as it does now.

Nearly seventy-five years ago public health nurses first began to go into homes. You and I have never known what it was to go into a home without a warm reception. Perhaps we have been met with coolness a few times because people did not understand, but rarely do we have to think of how to seek entrance because that first group of nurses made an open door for us. Some of them are only names to us, but some we have had the privilege of knowing personally, and through Miss Gardner, our Honorary President, we know their spirit vividly. That open door is a precious privilege and one which we often fail to realize because we have always had it. It is the privilege of the readiness of our patients for our service. Our task is to hold that privilege, to use it always wisely in the homes of our patients so long as public health nursing or any nursing shall be a part of the world's effort for the welfare of mankind. It is that privilege which this organization strives always to enrich—to enlarge. Enshrined in this privilege of our patients' readiness for our service is our own well learned knowledge that help comes through working together to solve problems. In our togetherness with others lies our strength.

We felt it so strongly that when we formed our own national organization in 1912 we were unable to think of working for our patients without our board and committee members. The opportunity, the constant inspiration, the courage and the strength that have come to us because of that combination—first nurse and patient, then board member, nurse and patient—have led us on through each decade of our national life to work with and through the other people in the world who are concerned with the welfare of mankind.

Now we have the Structure Study and all that it may mean for us and for nursing in our country. The problems are numerous and large, but in a way they are like a tiny model of the United Nations. Our ability to solve these problems of nursing so that patient and nurse both come to a fruitful solution of their difficulties, our relationships within the profession, our ability to work with every other organization in the community, contributes directly to the ability of the fifty-one nations in the UN to construct a world structure for enduring peace.

When you joined NOPHN you became en-

NOPHN's new president for 1946-1948, Miss Hubbard made these remarks upon taking office at the NOPHN closing business session, Biennial Convention, Atlantic City, September 27, 1946.

titled to wear a small pin that bears a motto. Perhaps mottoes are no longer in style, but I still retain a childhood memory of mottoes as guides to behavior. "When the desire cometh it is a tree of life." Trees have a life far longer than that of human beings. Therefore, I take it that our task, our opportunity, is to make this organization in any form that it may take,—so rich, so great in its service to our patients in this country that its life will go on fruitfully far beyond our own lives.

REPORT OF THE HOSPITAL COMMISSION

HIGHLIGHT of the 48th annual convention of the American Hospital Association was the report on the findings of the Commission on Hospital Care. This Commission, under the direction of Dr. A. C. Bachmeyer of the University of Chicago, has functioned for the last two years. Its 700-page report, "Hospital Care in the United States," to be published early in 1947 by the Commonwealth Fund, is an exhaustive study of the subject.

Much of the material in the report will interest nurses, particularly the Commission's comments on nursing. The comments are extremely pertinent in these days when the nursing profession is trying to find its place in the postwar world. Nursing, the Commission states, is the most complex of all hospital services. If a nurse is to be successful she must be a leader in her community, and therefore a woman of broad education, professional and cultural. The Commission believes that nursing schools should be administered only by colleges or by large hospitals with connections with other hospitals and public health agencies in rural and urban communities. Affiliations for student nurses, it further states, should be provided only with hospitals or agencies meeting high standards of education and service. The Commission notes an increasing demand for male nurses and recommends that opportunities for training of male nurses be increased. It believes that a high quality of nursing care can be given economically if the professional nursing staff is augmented with auxiliary workers.

Only a few of the Commission's other 175 recommendations can be mentioned in this brief summary. The report recommends specifically that the general hospitals become *general in fact as well as name* and expand services to care for all patients. In small communities it is suggested that space be planned to care for patients with communicable diseases and that hospitals give consideration to the needs of convalescent and chronically ill patients, and to rehabilitation care.

Further recommendations are that hospitals should have broadly representative local advisory boards. All efforts must be made to coordinate hospital services with those of public health agencies.

Hospitals are advised to make diagnostic facilities available to all medical personnel of the community, whether or not on the hospital staff, and to cooperate with the medical profession in establishing group practice programs. Hospitals are to cooperate in prepayment health insurance plans as a further effort to insure good patient care.

Medicine today is defined by the Commission to be as much a social science as it is biological. Plans for medical care must fit into the modern social scene. The problem of spreading total cost of medical care over a large part of the population for over a long period of time obviously indicates some type of insurance plan. Medical care insurance is a logical next step for the American people to take, but regardless of what system of coordination of plans is established, the Commission is strongly in favor of local administration of programs.

In summary, the Commission on Hospital Care reports that there is a growing conviction that the general hospital is the keystone in the community for all hospital services. The essential function of a hospital is service, and service must include preventive, curative, and rehabilitation programs. The present personnel problem is not a shortage of physicians but one of distribution, but financial inducements alone are not enough to attract young professional workers to rural areas. There should be a system of interrelated hospitals and health agencies with complete hospital facilities as the focal point and services stemming from one large teaching center down into the hearts of small communities.

Recognition must be given to the importance of nursing service. Much of the success or failure of a hospital to fill the needs of a particular community depends upon its nursing staff. Since hospital service is personal service, people who are to use the service must participate in the planning and administration

National and International Horizons in Health

By THOMAS PARRAN, M.D.

FOR THOSE of us in the health and medical professions, these are stirring times. Challenging new opportunities for service are opening before us. We might compare today's developments with the era of medical pioneering in the latter half of the nineteenth century when the contributions of such workers as Pasteur, Koch, and Lister gave modern medicine its scientific foundations. Then, as now, a flood of experimental advances fired the imagination and stimulated achievement. Today, however, there is the added frontier of equalizing the opportunity for health—of applying completely all of the knowledge we have for everyone wherever he may live and whatever his race or economic status.

On the present horizon, vistas of new scientific victories are breath-taking in their promise of improved health, if we not only expand but learn to utilize this knowledge wisely for the benefit of all mankind. The antibiotics, of which penicillin is the best known, promise further to revolutionize the treatment of many diseases. Our understanding of the basic physiologic and chemical mechanisms of the human body is growing apace.

To these advances there has recently been added a new tool which may prove to be as valuable in research as was the microscope. I refer to the use of isotopes and radioactive or tagged atoms, which being traceable and identifiable should enable us to unravel many heretofore insoluble biological mysteries.

New chemicals are constantly being produced, some of which in other fields may rival the sulfanilamides or DDT as effective weapons. For example, chloroquinone developed in wartime by intensive teamwork among hundreds of scientists, is much more effective against malaria than quinine or atabrine. We have barely tapped the seemingly inexhaustible storehouse of chemistry.

Slowly the new disciplines of psychiatry and psychology are giving us an understanding of the human mind and of human behavior, which should contribute not only to the prevention of mental breakdown but to the improvement of man's ability to live more harmoniously with his fellows.

These are but a few of the many promises of science. Equally exciting are goals which seem within our reach in putting science more fully to work for the benefit of all peoples.

Although we have made significant progress in raising the standards of health in our Nation, there still are many serious gaps. At its best, American medical care is the finest in the world; but there are too many areas of our country, too many groups of our citizens, to whom the best is not available. The striking differences between states in infant mortality is a case in point. The national average is down to about 40 per thousand, but there are states where nearly 100 of every thousand babies die before they are a year old. We find the same divergence in the ratio of deaths of mothers in childbirth. Five states have a rate which is double that of the states that have made the most progress. Recent data also show us that three-quarters of our rural communities still lack maternity clinics or centers. One-fifth of our counties have less than one physician to every 3,000 persons, and many communities have no physician. Progressively fewer young doctors are settling in the smaller communities where they lack modern hospitals. Over 900 counties have no public health nurse—a primary health need—and only 60 percent of our counties have a full-time health department.

Dr. Parran is Surgeon General of the U. S. Public Health Service.

RECOGNIZING the need for leveling up the peaks and valleys in our health facilities and services, the Congress eleven years ago adopted a continuing policy of financial aid to the states for improving the public health. Eight million dollars originally were provided for general health and three million dollars for maternal and child health. The results of these programs encouraged the Congress to supplement them by additional federal action against specific diseases of national importance. I refer particularly to cancer, the venereal diseases, and tuberculosis.

Since 1900, tuberculosis has dropped from second to eighth place as a cause of death in this country. Almost every state now has a full-time tuberculosis control program. New case-finding technics recently applied on a nation-wide basis make possible early treatment and isolation.

If our current methods are expanded, we can look forward in a few years to reducing tuberculosis to the level of typhoid fever.

Ten years ago, syphilis necessitated a 70-week treatment. Today, syphilis in its early stages can be treated in nine days to two weeks. Studies recently completed show remarkable progress since enactment of the Venereal Disease Control Act in 1938. The estimated number of new cases of syphilis now occurring has been cut in two—from half a million new cases in 1936 to a quarter of a million in 1946. Much of the progress in the control of venereal disease was made possible by a coordinated nationwide attack. Aided by penicillin we have widely applied safe, rapid methods for treating syphilis and gonorrhea.

The success that has marked these programs of federal-state-local cooperation has led to increased federal support in new and important areas for combatting sickness and death. Increased funds are now available for a cancer control program to be operated by local health departments. Facilities will include tumor diagnostic clinics, laboratory service for tissue diagnosis, more and more competent cancer treatment centers, and public education about cancer.

Another step forward in forging the tools for better public health is the recently passed Mental Health Act, the first example of permanent federal legislation to provide grants-in-aid for medical education. Funds will be made available to educational institutions to train psychiatric nurses, psychiatric social workers, psychologists, psychiatrists, and other professional personnel needed to expand present knowledge as well as to apply the scientific knowledge now at hand. Funds also will be available to provide individual fellowships for research and for training; to build and support a National Mental Health Institute; to give grants-in-aid to scientific institutions for research projects designed to elucidate any phase of this problem—even to support mental research institutes here or abroad.

Our insight into mental diseases and their interrelationships with the physical, is primitive. Our present knowledge, historically, is comparable with our knowledge of infectious disease before the time of Pasteur.

There is this difference. This Nation by Congressional mandate has authorized a national—even a world-wide, research effort.

ANOTHER important piece of recent health legislation is the Hospital Survey and Construction Act. Through this legislation we hope to create the framework for a nation-wide system of hospitals and health centers, basic in providing adequate health services to all the people—whatever the methods of payment may be.

As the name of the Act implies, the program is divided into two distinct phases. The first calls for statewide surveys of hospitals and related health facilities, and for the preparation of master plans which will provide for all of the people of each state adequate physical facilities for health. Each state plan must list needed facilities in the order of urgency. The second phase calls for a construction program of over-all objectives in order of need.

It should be emphasized that the Hospital Survey and Construction Act is not another federal works program. It is solely a grant-in-aid program. It delegates the major share of responsibility to the individual state. A single agency of the state government will administer each phase of the program, and a state advisory council, composed of technical and consumer representatives, will participate actively. The role of the Public Health Service and the Federal Hospital Council is largely that of guidance and approval, plus the granting of funds.

The relative need of any state for additional

hospital facilities is recognized as an important consideration in distributing construction funds. Allotments are based on a formula using two factors, population and per capita income. States where the need for hospital facilities is greatest will receive more money per capita than the wealthier states. For every project, however—and this is a defect in the Act—there must be two dollars of state or local money available for every dollar of federal funds.

Although this Act is the next needed step in developing a national health program, it has certain fundamental weaknesses. It does not provide any funds for the maintenance and operation of hospitals after they have been built. This was an obvious omission. As a result, the areas most in need of hospitals may not be able either to supply two-thirds of the construction cost, or to support a hospital once it is built. Nevertheless a start is being made; such obvious defects can be corrected.

The Public Health Service in Washington is deluged with inquiries asking, "How can we get a hospital in our town?" The answer is simple: the Public Health Service can do nothing to help you. You must work through your state hospital agency. When your state has completed a survey of existing facilities, when the state agency has approved a master plan showing the total needs of your state and recommends your project as having priority, it may be approved.

This Hospital Act will contribute greatly towards a total national health program. Other essential steps required to assure equal opportunity for health to all groups in all areas of the country are:

1. A better distribution of doctors and other medical and health personnel throughout the country. The hospital law aids this objective indirectly.

2. Full-time public health departments in every part of the country. We now can move progressively toward this basic objective.

3. Strengthening of professional education in medical and related fields. Only in mental health has any action been taken.

4. Encouragement and support of medical research. The Public Health Service has the authority in law—it is giving effect to that authority by giving more grants than ever before.

5. A workable plan which would give each individual ready access to all necessary medical, hospital, and related services by prepayment of costs through taxes or insurance. On this sector little progress has been made. As you know, the Wagner-Murray-Dingell Bill has not been reported out of committee.

In planning our health and medical services for the future, the basic consideration should be the availability of such services to all in proportion to biologic need and not in proportion to a paying ability.

YOU OF THE NURSING profession have much to contribute. Without good nursing, no national health program can be effective. Excellent opportunities are ahead of you. If you are to take advantage of them, certain fundamental changes must be made within your own ranks. In nurse education, obvious reforms are long overdue.

The experience of the Public Health Service in the Cadet Nurse program confirms the well known discrepancy in the quality of nurse training. The fundamental weakness is that most of the 1300 nurse training schools are not primarily educational institutions but merely apprentice training adjuncts to a hospital. Dependent upon the hospital budget and service needs, you cannot hope to set up uniform standards or obtain your full professional stature until your schools have a separate identity as educational institutions. The present system places student education in competition with the needs of a hospital. Until the two are separated administratively and financially, neither the best education nor the best service can be achieved.

You nurses should have a keen interest in democratizing health and medical services. The nurse traditionally is closer to the people than the doctor or the scientist. Her intimate contact with community life makes her particularly sensitive to the need for medical and health care. This is doubly true of the public health nurse who long has been recognized as the backbone of the local health department —the spearhead of the whole public health movement. The training and experience of all nurses, and their innate humanitarian qualities as well, equip them uniquely to advance the ideal of assuring to everyone the right to good health.

Outstanding representatives of nursing in this country have taken their rightful place both in the national and international sphere.

Not content with your dramatic wartime achievements, you have pooled the resources of your professional organizations and have developed forward-looking plans to improve nursing education, standards, and services. Your National Nursing Planning Committee is to be congratulated upon its realistic "Comprehensive Program for Nationwide Action in the Field of Nursing." This functional plan sets goals which you will reach through your re-formed organization about which I have just heard today. I congratulate you on your plans for unification, for a broadened base of leadership, for vital participation by every nurse. Seeing the general health needs as I do, I believe you are wise to consider participation of community leaders and other professions in your organization. Only as you identify your purposes with those of others who aim similarly, will you make nursing service available to all our citizens. I challenge you to rapid action and knowing the spirit and stamina of nurses I predict success.

I have heard too of your attempts at improvement of employment conditions. Progress on this sector is sorely needed.

GREAT AS MAY be our shortcomings in the United States, not only in nursing but in our whole public health system, they are vastly multiplied on the global front. Except in a few countries, nursing is less well developed than here at home. Consider the plight of China. Our most reliable estimates tell us that her 400 million people are served by less than 10,000 nurses—approximately the number expected to attend this Convention. There is even more to do, therefore, on a world scale in developing a public health system which uses fully nursing as an essential discipline.

A beginning has been made in promoting world health. In July of this year in New York City, 61 nations signed the Constitution of the World Health Organization—a Magna Carta for World Health. As guideposts, we have had many decades of experience in international health teamwork. I refer to the Paris Office of Hygiene which administered sanitary conventions and exchanged epidemic intelligence; the Pan American Sanitary Bureau, a pioneer international health organization in this hemisphere; the Health Section of the League of Nations, which developed an effective international health program; and the current health and medical work of UNRRA.

The Constitution of the WHO proposes a single worldwide health organization supported by governments. It defines health not merely as the absence of disease and infirmity but as a state of physical, mental, and social well-being, which is a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition. It gives to the World Health Organization this objective: attainment by all people of the highest possible level of health.

All nations recognize the need for concerted action to raise the level of health all over the world. We know well that many countries have never enjoyed even such a fundamental prerequisite to good health as a sanitary environment. Vast millions of the world's population have never had access to an unpolluted water supply, modern hospitals as we know them, maternal and child health services, and technics for preventing communicable diseases. Moreover, many countries that had progressed far toward providing medical facilities and services to their citizens, suffered paralyzing setbacks because of the destructive forces of the recent war. In Poland, for instance, with a 33 million population, the war destroyed 50 percent of its doctors and 75 percent of its hospitals. The Netherlands' population of 9 million, with a prewar record of 7½ hospital beds per thousand and 6,000 doctors, lost 30 percent of each. Greece lost 40 percent of her 7,000 doctors and 30 percent of the hospitals that had served her 7 million people. The 41 million French citizens emerged from the occupation less 30 percent of the prewar level of 5 beds per thousand and 24,000 doctors.

Our desire to render service to these less fortunate regions is one compelling reason for our cooperation in the World Health Organization. But the United States also has much to gain from improvements in the health conditions of other countries. It is a matter of history that great advances in science are not confined to any single nation, that microscopic life was discovered by a Dutchman, antiseptic technic by an Englishman, the germ theory of disease and immunization by a Frenchman. During the recent war, scientists from other countries developed some of the most powerful weapons against disease: penicillin, the sulfa drugs, DDT, atabrine. No one would dispute that health conditions in the United States would suffer if we were deprived of

the advances in science made by other countries, nor that public health throughout the world will be improved when every nation contributes to a common goal of knowledge through the World Health Organization.

Such organized international cooperation will stimulate and coordinate research leading to new medical victories. It will establish standards for drugs, for health practice. It will help combat health menaces wherever they exist. It will help to train health personnel. It will be in fact a World Health Center.

Even before the days of rapid transport, it was recognized that disease knew no national boundaries. As long ago as 1851, international health action was taken to establish quarantine regulations against cholera, plague, and smallpox. With a functioning World Health Organization, we will no longer need to depend upon outmoded quarantine barriers but will carry on an aggressive program to attack these epidemics at the source wherever they flourish.

IF WORLD HEALTH efforts are to succeed, there must be peace. Moreover, the spirit of cooperation which must prevail among nations must also prevail among the voluntary and professional associations now operating in the international health field. Important contributions to world health will continue to be made by such groups as your own International Council of Nurses, and the voluntary associations which have carried on international programs for the control of tuberculosis, venereal disease, and other illnesses.

At this time, while the plans for a world health organization are still being formulated, it is most important to consider the future status of these voluntary and professional organizations. There should be no official control of the policies of these groups by the World Health Organization. On a national as well as an international scale, such organizations have found in their independence a fundamental source of strength and rich vitality.

This freedom has enhanced their success in developing new scientific technics and procedures, in stimulating higher professional standards, and in encouraging governments to take over responsibility in needed areas. While it is desirable for these groups to maintain their autonomy, they naturally will work closely with the World Health Organization, and can be assisted by it in many ways as mutually agreed.

This progress toward achieving better health for everyone, which we see both nationally and globally, will have revolutionary effects on our professions. We must adapt quickly to the rapidly changing demands that will be made by our own members and by the public, if we are to meet the opportunities and responsibilities in both a national health program and a world health program. We must be among the leaders in developing and using the new fruits of experimental effort. We must do all we can to equalize the opportunities for health for everyone.

You nurses have set basic objectives for your profession. I urge you to take immediate action in achieving these goals. With that accomplished, you can be confident in your ability to assume leadership, in advancing toward the broader horizons of better health for our nation and better health for all the world.

Presented before the Joint Session, "World Health —Today and Tomorrow," Biennial Convention, Atlantic City, New Jersey, September 24, 1946.

The New NOPHN Personnel Policies Guide

By LEAH BLAISDELL BRYAN, R.N.

ONCE MORE the National Organization for Public Health Nursing has done a real service by sampling a very important ingredient of good public health nursing, namely, personnel practices, and developing therefrom some guideposts for action.

Like all of our guides, this beginning document should be considered experimental and subject to the improvement that grows out of its use. It is the obligation of each of us to contribute to that experience and improvement.

The present widespread concern with improved personnel administration springs, I believe, from the urge of intelligent human beings, renewed as wartime restrictions are relieved, to guide their own destinies more completely and to make their contributions felt in the work to which they give so large a share of their time, energy, and thought. Recent experience with groups of nurses in very troubled areas makes me believe that the desire to serve well is as great in professional nurses today as the desire for larger salaries, shorter hours, and more privileges. They long for an unobstructed channel direct to the administrator and governing body, through which they may make their contributions and grievances known in a frank, wholesome manner. They earnestly hope the consideration given their communications will be that usually accorded a partner in business—honest and frank, whether favorable or to the contrary.

That is what the new guide implies in its first section on general principles and methods. But I wish we all could outdo, during 1946 and 1947, the guide's recommendation (principles 6 and 7) that agencies should have personnel committees serving in advisory capacity with the end responsibility for personnel policies vested in the administrator or governing body. I'd like to see every agency have, not just the "advisory committee" which sends recommendations to the board for their "final determination," but a personnel committee with more final authority, comprising official representatives of staff nurses, supervisors, and administrative nurses, *and* of the board in which suggestions and requests of all these groups could be talked through on a partnership basis. It would be a great morale-building and work-stimulating dynamo, in my opinion.

With that in mind, I would like to move the section on Staff Council now placed toward the end of the guide right up to an important place at the beginning. This section provides for organizing staff opinion on all of the personnel policy questions and I believe it should further provide for the election of official staff representatives to the personnel, staff development, and other policy-suggesting committees of the agency. Contrary to the principle expressed in the guide, I believe the staff organization and its executive body, the staff council, should be made up of staff nurses only and that supervisory nurses should have their own group organization and representatives. The members of each group will express themselves more freely when by themselves and can learn to do so in a professional manner. The real aims of each group need to be crystallized for action.

The NOPHN committee which has compiled this guide has clearly and wisely vested the administration of policies in the personnel director or person functioning in that capacity in order to provide continuity and avoid con-

Mrs. Bryan was, during the last biennial period, a member of the Board of the National Organization for Public Health Nursing and, from 1942 to 1944, chairman of its important Education Committee. She was formerly acting director of the Visiting Nurse Service of New York.

fusion. This should not, however, imply that she can carry the responsibility alone. As I see it, each supervisor is her assistant, with major opportunities and responsibilities for making this partnership plan of personnel administration work. The personnel director gives guidance and coordination to this part of the supervisor's work.

A more unique suggestion is the provision (principle 8) for a committee or a counselor, one to whom the nurses are not administratively responsible, to care for problems or misunderstandings which interfere with the nurses' work. This is a very splendid safety valve, and one not to be the least bit feared if the counselor's function is clearly defined. The guide states that this counselor is to be appointed by the governing board, but I believe that the plan would be strengthened if the personnel committee were allowed to nominate persons whom they would feel free and confident to consult. Full discussion of the plan should be held, in which the nurses come to recognize that the agency has endeavored to provide fair policies and a regular channel for solving problems in a sympathetic, democratic manner. The counselor's contribution in such an agency should be to help the agency clear this channel and help the nurses use it with increasing objectivity.

I CANNOT GO further in discussing the guide without pausing to reflect a moment on whether or not public health nurses and administrators are sufficiently grown up and ready to believe in and practice this partnership philosophy of working together. It implies mature responsibilities for both the employer and the employee. Will administrators, nursing committees, and governing boards resent discussion of their habits as administrators and of new suggestions from staff nurses, or can they objectively explain the good ones and thank heaven for new light on the bad or fuzzy ones? Can staff nurses put their best effort into every job, whether or not they are supervised? Can they refrain from gossiping and "griping" about persons and policies and present their reasons for disagreements with the status quo in a mature, objective and convincing manner to their supervisor, their director, and even to the board of directors, if need be?

Right now is the time to be honest, before launching into a progressive personnel program. If an agency is not convinced that it is ready (barring, of course, human errors on the way), it had better set up a new set of rules and regulations and go ahead with as fair and firm execution of them as possible until convinced of the joys and practicability of the partnership plan. In that system, both the employer and employee must be prepared to learn a great deal from one another, to laugh at their own shortcomings and failures, and try again. Each partner will understand the other's problems, believe in the other's sincerity, and help the other up and onward.

The recommendation of the guide that nursing agencies work out policies in cooperation with other allied agencies in the community is particularly timely and important. Differing hours of work and salaries are troublesome stumbling blocks in community coordination of nursing service. This is one hurdle that could be attacked by the nurses themselves in all communities at once.

Now may I skip hurriedly through the sections and point out the items which are more controversial, or illustrate the forward-looking philosophy of this guide. Omission of a few does not mean that they are unimportant to me.

The preemployment procedures suggested are commendable. We are indeed fortunate in having had NOPHN recommended qualifications to guide and strengthen us over the past 15 or 20 years. Nevertheless, their application in an organization by committee selection of appointees, based upon carefully compiled credentials and tests, has proved to be a safeguard in securing a good staff and a protection of applicants against the more personal decisions of one person. Incidentally, supervisors who have assisted in this type of selective process have gained a much clearer picture of the necessity for individualized orientation and guidance of new staff members.

The temporary or probationary appointment plan is another commendable key to a good staff. One wishes it were used more effectively in both official and voluntary agencies. It is the sacred duty of supervisors, backed firmly by administration, to redirect the nurses who do not show real aptitude for this exacting public responsibility, before both the nurse and the agency waste valuable time and money trying to fit a square peg into a round hole.

In the section on Time, the partnership prin-

ciple may well be invoked. Public health nurses will be glad for this official endorsement of the 40-hour week. May it soon universally prevail! But a 40-hour week will ruin an organization, unless every nurse uses the 2400 minutes of that work week in a business-like manner. At work on the dot of the hour; swift, clear planning and execution of the day's or week's plan, use of non-professional help for activities not requiring professional care, group work when it will save time; preventive care of equipment and care—these are the signs of the nurse working in partnership with her employer.

Letting the group decide on a sensible variation from the usual work hours, set up the policies for governing rotation of evening or night work, or decide on the amount of time and hour for lunch, may be more time-consuming than setting a rule, but that is a small price to pay for a policy that really works. An administrator who tries such a plan with a well selected group of nurses usually finds that the nurses are fair, yet more exacting than she.

Recognition of overtime work is another commendable item in this guide but I am aware that many nurses consider payment for overtime work beneath the dignity of professional nurses. On the contrary, this is a realistic approach to a perplexing problem. Making up time—the usual custom—has never seemed too successful to me. Continuous overtime by a good group of staff nurses means that they are over burdened. Having them take time off on another day only increases their frustration, as well as that of the supervisor. Payment for planned overtime concretely draws the attention of the administrator to understaffed sections or too liberal intake policies of the entire agency. Experience with such a plan indicates that it is rarely misused and then only by an occasional nurse who shows other evidences of unscrupulousness. Payment for overtime deserves careful consideration.

IN THE SECTION on Salaries the guide wisely omits quotation of salaries but states principles for arriving at them locally. I am inclined to believe that these ranges should be recommended on a statewide basis in order to assist the nurses in small agencies. Just as important is the leeway suggested in placing the new worker in the salary range and accelerating her increments. The key to keeping this fair is that it be done by more than one person. I hope that we can understand that such variations, especially postponement of increments, should be thoughtfully discussed with the nurse affected.

The guide's health program is conservative, but points in the right direction. The examining physicians, the guide states, should be approved by the agency. I would add, they should be approved by the personnel committee of the agency, so that the nurses, themselves, may assist in selection. The age-old problem of keeping the professional relationship between the examining physician and the employee on such a basis that the agency's interest is served as well as that of the nurse does not appear to be solved. It is hoped that some mutually acceptable plans will come out of further discussions. Health provision is one area in which the individual nurse's responsibility is high, particularly when she is a public health nurse.

The staff development suggestions will, I hope, be amplified in future revisions. A plan for a permanent committee of staff nurses, supervisors and administrators, including the governing body, to work with the educational director in mapping and revising a long-term written plan for staff development, would do much to bring forth leaders for the next generation. Only by careful and forceful planning and interpretation to the governing board will funds be made available for this important task. It is the lifeblood of the future.

I have already spoken about the staff organization or council to some extent, but I should like to add one more thought. The opportunity of having an official channel through which the nurses can participate in policy formation is a great privilege. Not only should the leaders and official representatives be chosen with great care, but they should recognize that a reasonable amount of personal time and energy will be required of them. Only those who can see that the growth value to them personally and professionally is worth this contribution should accept appointment.

The question of retirement plans no longer seems to be, Should there be one?—but rather how may we arrive at a plan to cover those not already cared for. That the profession,

(Continued on page 597)

New Ways in Personnel Administration

By F. ALEXANDER MAGOUN

AMONG the fine and jubilant summaries which clever men so love to make is the abstraction that the job of management is to direct, to develop, and to control. As with many generalities, this skeleton of words comes alive only when clothed with the quickening tissues of an understanding which goes far beyond the superficial search for a set of rules. And yet so many people in positions of authority search diligently for rules by which to administer the handling of a staff.

There are areas in which rules operate successfully. The cook, the plumber, and the laboratory technician follow them constantly. But handling people is an art. Would John D. Rockefeller have paid more for the ability to lead men than for any other quality, if it could be done by a set of rules? Handling people is an art to be successfully achieved only by knowing and following the fundamental principles in your own individual way, which must, however, be completely sincere.

To direct, to develop, and to control does not apply just to men, nor to methods, nor to money, nor to materials. It requires expert attention to all of these, and all at the same time. In a large organization this becomes so complicated as to require specialists to protect the various points of view: a treasurer to think in terms of money, a purchasing agent to think in terms of materials, a personnel director to think in terms of people. It is this "thinking in terms of people" with which we shall concern ourselves.

"Personnel Administration," says the National Organization for Public Health Nursing booklet on *Personnel Policies*, "is the direction and coordination of the human relations of any organization with a view to getting the maximum production with a minimum of effort and friction, and with proper regard for the genuine well-being of the worker." Personnel administration is doubly important because a mistake made in handling a piece of apparatus is a temporary thing; a mistake made in handling a person can have long run consequences.

Last spring an executive in one of the industrial concerns for which I am a consultant said to me, "Because of the things that have been changed here in the last two years, I've just been to my boss about something he did to me that I didn't like. We've got it all straightened out now, and I feel better."

"That's fine," I replied, "but there's one thing I'd like to know. How long ago was it that the boss did whatever he did?"

"Eighteen years."

Can any accountant compute the loss to that company resulting from an executive who for eighteen years worked without a willing heart? We usually do a magnificent job handling machinery, materials, methods, and money. We often do a poor job handling men. The present trend of trying to understand why people behave the way they behave is long overdue, and the only new thing in personnel administration I want to discuss with you this morning has to do with understanding the individual.

Any institution serving the public faces the necessity of finding sound solutions to the problems in human relations which beset the organization both within and without: internally in the form of directing, developing, controlling personnel; externally in the form of building good customer and community relations. These two problems are inseparable and interdependent. Employee attitude toward the organization and the public is a prime factor in determining community and patron response; community and patron response determine not only the prosperity of the organization but its very existence. The ef-

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fectiveness of the solution of any internal or external problem in human relations will, therefore, be reflected in the degree to which it makes the organization a better group with which to do business. And the most complete understanding possible of why people behave the way they behave, is vital to the success of any enterprise because profits depend upon it.

THE GOAL of a good administrator is a cooperative team, in the building of which, under the complex conditions of a modern factory or hospital, a systematized organization and a well established tradition of good discipline are necessary. Good group control depends partly on right organization; and partly on sound individual correction, reward, and punishment. How the individual is treated is extremely important because an executive is never dealing with just one person. Fifty others are watching to see what he does and how he does it. Quite rightly they then decide what they can expect under the same circumstances.

There will, to be sure, be regulations which must be followed, but if they are to be effective they must be few, simple, clear, and confined to inflexible rules, such as, "working hours are 8:30 a.m. to 4:30 p.m." The difficulties of an administrator begin at the point where objective inflexibility ends. "Poor quality work is not acceptable." Where does poor quality begin? "Edith must do a better job of taking care of her patients." At exactly what point is it a sufficiently better job? It is in the successful handling of indefinite, individual incidents that good leadership shows. Where regulations are wisely interpreted and acceptably administered in the unusual case, the workmen will want to live up to the spirit of the regulations in the ordinary situation. Bungled too many times in the unusual situation, men no longer have a "group willing heart" even in the usual situation.

Suppose the office boy asks for time off to go to his grandmother's funeral. The boss remembers that the World Series is being played, so he dismisses the lad with a cynical, "No! Certainly not." But if grandmother really has died, nobody in the office will forgive the boss for his bad judgment. To discharge his responsibilities in personnel administration successfully, he MUST know enough about people to be able to tell when someone is lying and when someone is telling the truth.

What we all want is to be understood sympathetically. This often involves knowing more about the causes of a person's behavior than he himself knows. This, alas, is seldom realized. We teach engineers about machinery, lawyers about statutes and jurisprudence, clergymen about theological doctrine, doctors and nurses about anatomy and *materia medica*. Many of them are soon in positions where they are handling people even more than they are using their technical knowledge. Yet almost none of them are given any education in why people behave the way they behave. This is all the more tragic because what a person sees in any situation is always a function of what he has learned to pay attention to.

Everybody knows something about human relations. "Expert" derives from the word experience, which makes it natural enough to mistake the possession of authority for knowledge, particularly since so many people with power believe humanity should be divided into those who order and those who obey. Private imperialism!

Actually, of course, executives need to realize that everybody has power. Even the little new baby can hold his breath until he turns blue in the face and scares his mother into submission. The child, abused by an unreasonable father, can bang his head on the floor almost to the point of self-injury, and so summon mother to his defense. The adolescent—and the grown-up who is emotionally immature—becomes stubborn, as one of the last methods by which a person who feels weak is able to defend himself against unreasonable authority. Everybody has power. The variable is how it is used. Furthermore, no one ever has any more authority over an individual than he is willing to accept. The Roman soldiers crucified Christ without achieving one whit of authority over Him. Similarly the Greeks gave Socrates hemlock.

People are willing to be subordinate to good leadership, but they are not willing to be subservient. It is not enough for management to have authority. It is not enough for it to be honest. It is not even enough for it to be right. Management must be effective, and in order to be effective it must also be able to deal acceptably with emotions—the driving force behind all human behavior. Nothing short of completely sincere and competent

know-how in handling emotions as well as finance, methods, apparatus, and materials will do.

No organization has meaning except in terms of the relatedness of its components. This is even true of the atom and the molecule. The same raw material in different relationships leads to vastly different results. Sugar, alcohol, and many other substances are made from carbon, oxygen, and nitrogen atoms in differing relationships.

Men, like atoms, have an innate need to work together, but like atoms, they show preference to do it with some people rather than others. For example, people can work together successfully only when they are sincerely motivated by the same sort of emotional reactions. A trusting person cannot long cooperate with a suspicious person because the suspicious individual is unable to respond sincerely in a trusting manner. Very soon what he does is to make the trusting one feel suspicious, and consequently, to get his emotional dukes up in self-defense. But two trusting people create a positive inter-personal relationship of confidence, and two politicians look upon each other's trickery as all part of the game. "He beat me this time. I'll get him next time."

Yet how often someone in an administrative position will order two such people to cooperate. He might as reasonably order oil and water to mix, the one difference being that because people have emotions—which atoms do not—by applying enough pressure the boss can often get a superficial, temporary, bogus cooperation, which, in his ignorance, he wishfully mistakes for the real thing.

WHETHER OR NOT an individual is trusting or suspicious depends upon the experiences of his early childhood. After a half century of life, and a quarter century of professional experience, it is my considered opinion that all troubles in human relations stem from mistakes in the way children are brought up. Your troubles come from what was done to you, or what was done to the people you have the responsibility of handling, or combinations of both.

Due to childhood experiences, we soon habitually assume a standard pattern in explaining the motives of other people: they can be trusted, or they cannot be trusted; they are cooperative or antagonistic; they are kind or cruel. This pattern begins to be formed as soon as a baby is born. It is well established by age two. It is deeply set by age seven or eight.

By way of illustration let me tell you about an experience I had in 1945. The hospital was crowded, and in the beginning my room was shared with a little new baby. When they brought me back from the operating room the baby was moved into the corridor. Early that evening he began to whimper in a manner that said, "Please won't somebody love me just a little. I feel so much alone." Because of the whimper the nurse wheeled his crib into the operating room and closed the door, whereupon the baby bellowed with rage. Presently he wore himself out and went to sleep, so the nurse brought him back into the corridor where it was easier to keep an eye on him. An hour later the whole thing happened all over again: whimpers, ostracism to the operating room, anger.

Next morning after the head nurse had looked me over, I asked her what the matter was with the baby. "We don't know," she answered, "We can't find anything physically wrong, yet he doesn't gain weight as he should be doing after two weeks. We don't know."

"I think I can tell you."

She looked at me after the manner of head nurses and awaited my explanation. "That baby isn't being loved and he knows it already. His mother didn't want him, his father doesn't care about him, and sensing this he has no zest for life."

She thought a moment. "Well, you may be right. Anyway, you are correct in supposing that his mother didn't want him and his father doesn't care about him."

It is thus that we soon form habitual patterns of explaining the motives of other people. Then, instead of examining motives analytically, we proceed as though our assumption were correct for everybody. Soon other people respond in terms of our behavior, and thus do we reproduce in new environments the kind of environment we experienced in childhood. Dominated children grow up to become frightened adults who either habitually give in, try to dominate, or attempt to run away.

As Freud discovered, we tend throughout life to see the same insoluble things in various situations which we could not solve as children. It is so easy to feel, "I have failed in this

important human relation and I shall fail in every other." To the grown-up who experienced a down-trodden childhood, the person with power—the boss, the policeman, the income tax examiner—becomes very frightening. In every situation, such an individual relives the persecution he suffered from his parents or parent substitutes, and the quickest way to discover whether or not the person with authority is like father is to put him into a position similar to the roles father played. Then watch how he reacts. Father would never admit when he was wrong. Very well, maneuver the boss into a situation where he is in the wrong and see what happens.

If the boss is ignorant enough of the ways of human nature to construe this as a personal attack against which he must defend himself, instead of recognizing it as a test for reassurance on the part of the underling, the result will resemble two strange bulldogs at a bone party. Some day it will be unthinkable for anyone to have authority without knowledge of how emotions work.

THERE IS NO SUCH THING as meaningless behavior. Properly understood, all behavior is completely logical in the light of the nature of the particular person involved and the particular situation he is in. We are rapidly learning a great deal about this. Shall we take a simple case and examine some of the possibilities?

A public health nurse is called to a home where she finds a twelve-year-old boy confined to bed by a domineering mother toward whom he feels actively rebellious. He at once regards the nurse as an enemy because he considers her an ally of his mother. Consequently, he is completely non-cooperative.

What a difference it makes to realize how logical it is for him to think that the other people are entirely in the wrong. The fact of the matter is that in the beginning of his experience (or anyone else's for that matter), this was the truth. In situations involving a baby only the grown-ups are in the wrong.

What a difference it makes to realize that an unreasonable person is merely an irritated person who feels himself in a weak position and does not know how else he dares to express his anger. Perhaps the boy has a chip on the shoulder, in which case it is necessary to recognize it as merely the symptom of some one who expects severity, fears it, and so has his defenses up in anticipation of the attack. Show him he has no need to defend himself against you, and the chip will fall off by itself.

Perhaps this lad does not behave belligerently, but is floundering in the ooze of self-pity. Again, it is essential to be able to diagnose the self-pity as merely another indirect expression of anger. The emotionally mature person who feels himself injured says in effect, "Look what you've done to me. I'm angry about it and this is what I'm going to do as a consequence." His reaction may not be vindictive, but it is always open and overt. The frightened, subservient individual says in effect, "Look what you've done to me. Poor me. I'm angry about it, but because I'm so afraid I don't dare to show it openly. So I'll be sorry for myself. I'll let other people see what a brute you are. They'll see what you've done. They'll get even with you. Poor me." Tears are often a variation of this by which the weeping individual is asking indirectly to be handled in a less threatening manner.

Defiance is the other extreme. The boy again fears your power and wants to destroy you—or at least the power. But feeling too weak to undertake it openly, he accomplishes it figuratively by behavior which says that your wishes do not exist as far as he is concerned. He is subconsciously terrified by what he thinks would happen if you found out his true feeling (wanting to destroy you), so he rationalizes his attitude by saying, "This is a matter of principle with me," and thus hides, even from himself, the destructive desires which motivate him. Then the whole behavior mechanism comes full circle when subconsciously he punishes himself for his feeling of guilt by using the defiant attitude to make his behavior fail where cooperation would have succeeded. What a terrible burden such a person places upon himself because he cannot feel honestly.

Very often a parent, or teacher, or executive will attempt to order such an individual to be cooperative. It were as intelligent to order him to be bilious! He can do neither the one nor the other except under the circumstances which make cooperation or biliousness possible. Certainly he cannot be cooperative as long as he is emotionally dishonest with himself, pretending to feel what he does not feel, and pretending not to feel what he does feel.

Nor can the nurse, or anyone else, cooper-

ate with the boy until it is realized that to him, although he does not consciously realize it, "critical" and "hostile" mean the same thing. Under the conditions of his upbringing, criticism is to his emotions what a blow is to the body.

Like most of the rest of us, this lad deeply needs to find out what he is really feeling and why; this because emotion is the boss of reason. The analytical powers of the mind are but the tool of feeling. The happy person uses the mind in one way, the angry person in another, the frightened person in still another. This is why emotional honesty is far more important than financial or intellectual honesty because emotions are the driving force behind all human behavior. An emotion is a person's response to his feelings about a given situation: good, or bad. Emotional adjustment depends upon the honesty of his feelings and the reality of his value standards in relation to his true self and his true environment. Anything which is based on truth both subjectively and objectively makes for emotional maturity.

SUPPOSE THAT some days earlier, the boy's father had been stopped on the way home by a neighbor who exhibited a letter and complained, "Look what your son wrote me!" On examination the document proves to be an inventory of the neighbor's qualities as described by the boy in such words as, "stinker," "old meanie," "thief." Father can now do one of three things:

One. He sends Junior home and to bed with the promise of ,"I'll attend to you later!" This can only mean that the boy must be prepared to defend himself as best he can against punishment. New emotions will prevent his mind from analyzing the real truth about his feelings toward the neighbor and what they accomplished because now he mobilizes his emotions to protect himself against father.

Two. The parent can shrug his shoulders and ignore the whole thing. This also prevents Junior from coming to understand his feelings and their result, because now his emotion is, "Goody! I got away with it."

Three. Father can say, "Junior, did you write this? Let's go home and talk about it." In the privacy of their own living room, and in an atmosphere of mutual confidence, father and son can analyze the situation. "She must have done something to make you feel angry, or you wouldn't have written a letter like this. Oh, your ball went over the fence into her garden and she took it. Then she really did take someone else's property. Well, did you get your ball back by writing the letter? It's silly, isn't it, to do something that prevents the very thing you are trying to accomplish? What do you think would have been a better way?"

Through such a procedure the boy's feelings are not confused, and he can come to understand what he felt, what happened as a result, and whether or not the procedure is worth repeating. He needs also to realize that he will inevitably feel angry again.

The person who has only good emotions simply does not exist. To be sure, the Puritan struggles to disown those emotions which he considers evil, by burying them under ideals. These often keep him from realizing the disagreeable truth that every one of us is sometimes angry, hateful, jealous, afraid. Nobody is perfect and we should expect and accept this exactly as we expect and accept stormy weather.

We should go even further than that. Exactly as we need periodic physical cleansing of our skin or our viscera, so also we need occasional emotional baths to bring about catharsis of our feelings. There are times when people ought to get angry, not only for the value of the catharsis, but also because of what they can learn about what is going on inside themselves through an analysis of the anger. A good personnel administrator will sometimes deliberately allow a person to be angry just for this reason. There is a vast difference between repression, which leads to indirect rebellion on the one hand, and understanding, which leads to intelligent control on the other.

What we want is to put the boy we've been talking about into a situation where he can become cooperative. The desire for a cooperative staff on the part of many people in positions of authority is nothing more significant than a desire for the benefits of cooperation from other people—not a recognition of and responsibility for the discovery and establishment of those factors which are a prerequisite for cooperation. Management must perceive that the benefits of cooperation stem from the establishment of right conditions exactly as the benefits of an x-ray machine or of penicillin do. This is a matter so widely neglected by people in supervisory positions as to deserve detailed analysis.

IT IS UNREASONABLE to expect cooperation unless and until four conditions have been established:

1. *The people involved must have a self-respecting status.* This means recognition as belonging and being wanted; reasonable opportunities for self-fulfillment; emotional maturity; sound value judgments and the integrity to live up to them.

2. *The people involved must have a continuing and a healthy understanding of how the desires and the performance of each affects, and is in turn affected by, the performance and desires of the others in every situation as it occurs.* The point at which cooperation fails first is understanding. It is always difficult to endure what is not understood. This means the need for open channels of communication so that information can flow freely whenever and wherever needed; adjustment between individual desires and the requirements of the team; the sure feeling that legitimate wants will be satisfied without the need of fighting for them.

3. *The people involved must have confidence (because it is deserved) in the availability of and the effectiveness of good method in working out acceptable solutions for the inevitable disagreements which will arise.* This means a tradition of effective solutions, honestly arrived at, with the calm objective approach resulting from a minimum of self-assertion. Differences are of value only in-so-far as they stimulate new thinking. There can be healthy difference of opinion without emotional loss of unity.

4. *The people involved must accept mutual responsibility for results.* This means a satisfactory division of labor, put together in a single integrated pattern, with clear lines of authority, no cross-interference, and yet all working together for a common goal. Workers and executives are two parts of the same team, with interdependent powers and interlocking functions. The trouble comes when these are not correctly integrated. Such conditions cannot be established by following a set of rules.

God will never work a miracle to relieve you from the necessity of using your own common sense to analyze every situation and to discover the best way of handling it.

Many years ago I was awakened by a long-distance telephone call summoning me to the bedside of an aunt who was grievously ill. The doctor said, "No visitors." Two days later the nurse came to me saying, "There's a man at the door who has asked to see your aunt. Will you attend to him?"

Here was no violation of the doctor's orders, yet she contrived to make me feel that her woman's intuition believed we should admit the gentleman. He was someone I had never seen, nor had I ever heard his name. Nevertheless, I took the responsibility and escorted him to my aunt's room. She said nothing to him as he entered; he spoke no word of greeting to her. But as I closed the door behind the nurse and me, I peeked. The tall stranger was leaning over the pillow softly to kiss her cheek. Next day he came again, and as before stayed twenty minutes, only this time he went away carrying a rose she had given him.

That night, after the sunlight was dead beyond the windowpane, she peacefully breathed her last.

I found out later that he had started courting her when Grover Cleveland was in the White House. Neither had ever married, but down through the years they had gone on loving each other. What a mistake to have blindly followed a rule and denied him entrance! Would an hour, or a week, or even a month more of life have meant as much to her as that last twenty minutes when both of them knew the thread of a life-long relationship was about to be cut?

People in supervisory positions should never forget that it is not what you think you are doing for the other person that matters. The important elements are:

1. What he thinks you are doing
2. How he thinks you are doing it
3. Why he thinks you are doing it

And his feeling is often closer to the real truth than your own. If you truly have his interests at heart he will sense it. If you do not, no amount of talk will be convincing. Words are puny things, except where you have a receptive audience. Feelings are always powerful things. He will know whether you are only trying to have your own way, or whether you are trying to help him to tell you in his own way what the trouble is. The problem of good leadership is often not so much trying to understand the other person as it is understanding what is going on inside yourself. How you feel always determines what the other person senses.

There is in many of us a deep desire to dominate at any price. We attempt through kind acts to entice people into being subservient; we appeal to their loyalty, to their sense of duty; we tyrannize and browbeat, all because we are subconsciously so afraid of other people as to feel secure only when we have "power over." Yet domination is a psychologically unsound procedure because it destroys the willing heart and makes for rebellion.

In any event, what happens is not as important as what you do about it. What leads away from a situation is more consequential than what led up to it, and what you do is always in terms of how you feel.

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New NOPHN Personnel Policies Guide

(Continued from page 590)

as a whole, is working for inclusion of more nurses in the coverage of Social Security Act provisions is right. I hope all public health nurses will seek ways to help that movement. In addition, the guide recommends that every agency have a plan which will really make retirement at a reasonable age (55-60 years) possible and comfortable. I would like to make it even more emphatic, that the plan selected should be on a national basis so that nurses moving from one to another agency can continue under its provisions.

I hope these few highlights will stimulate study of the report and free expression of the reactions of staff nurses, supervisors, administrators, and board members to the plan. It will take a little restraint to avoid saying, "This doesn't apply to my situation, I'm a lone county nurse"—or, "It doesn't apply to me for I'm governed by civil service regulations." Instead, try to think how groups of county nurses might work out and implement these principles by joint action or try to remember that profound changes have been brought about in civil service regulations by both the workers and informed influential friends. Constantly I hear from administrators words to this effect, "We would like to try and help meet the nurses' needs, if they would only tell us clearly what they want." This guide is to help public health nurses think through what they do want.

As I see it, the implementation of personnel policies for all nurses will be most earnestly pressed by our district and state nurses' associations in the coming year. They will be asking, where it has not already been done, that SOPHN's or public health nursing sections of the state nurses' associations state their minimum recommended policies. The guide should help each state group to do it quickly and well.

I hope that conscientious efforts to improve personnel policies will bring ever-increasing joy and satisfaction to nurses in public health and that the newest generation will cheerfully understand some of us oldsters who have meant well but sometimes failed to be partners in every sense of the word.

Streamlining a Community Nursing Service

I. Preparing the Community

By MRS. CARROLL J. DICKSON

HAVING FELT for some time that a streamlined public health nursing service might accomplish certain desired objectives, the Bureau of Nursing of the Health Department of the City of New York and the Visiting Nurse Association of Brooklyn have agreed to engage jointly in such a service in the health center district in Brooklyn known as the Red Hook-Gowanus Health Center. These objectives are first, improved quality of service to the family; second, increased efficiency by avoiding duplication of service; and third, economy in use of personnel. It is believed that the pooling of the staffs with the resultant combined resources of knowledge, statistics, and consultant services cannot fail to bring better care to the patient. The shortage of nursing personnel is, if anything, worse now than during the war. It is obvious, we think, that with one nurse visiting a family both for health education and for home care she can avoid repetition of information and can accomplish in one visit what must now on some occasions be done in two.

Let us consider first the section selected for this demonstration. The Red Hook-Gowanus section is one of the thirty health center districts of the greater City of New York. It is bounded extensively by the waterfront and, as might be expected, is a highly developed industrial shipping area, having many docks, freight yards, terminals, warehouses, and factories. Its population is decreasing and according to the 1940 census was 176,229. Of these the two largest groups are of Irish and Italian ancestry. There are also quite a number of Syrians with a sprinkling of Puerto Ricans, Spaniards, Egyptians, Negroes, and a few other nationalities. During the war every effort was made to engender a neighborhood spirit among these nationality groups and some progress was made through the different civilian defense services. However, many barriers were not broken down and these still offer certain problems which must be met in any community effort. By far the greater number of persons belong to the lower income group. Included in the area, too, is the so-called "Heights" section which has many fine old houses and attractive apartments occupied by people of a much higher economic level. There are four hospitals and a medical college, a number of elementary public schools and one high school. Much of the housing is overcrowded and in most cases deteriorated although some of the worst slums have been replaced by the Red Hook housing project or demolished to make way for a super-highway which eventually will connect Brooklyn to Lower Manhattan by tunnel. There are many cold water flats which are all of very old construction. Other apartment house buildings are of the type of construction that dates back to the 19th century.

Certain special health problems are to be found. The infant death rate is very high, over 75 per 1000 live births. The mortality rate from all causes, including tuberculosis and pneumonia, is higher than in other Brooklyn health districts. There have been some deaths from diphtheria in recent years.

Health services are available for this entire area from the Red Hook-Gowanus Health Center, staffed by one full-time health officer and 23 public health nurses employed by the City Department of Health plus 11 members of the Visiting Nurse Association staff. Clinic services include child health clinics for infants and preschool children, chest clinics, venereal disease and maternity clinics, and cardiac clinics to which any school child in

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Brooklyn may come for diagnosis. Also there are eye and dental clinics for elementary school children. All patients delivered by midwives are referred to the maternity clinic for postpartal examination. Clinic sessions vary from three to six a week depending on the type. Persons eligible for emergency maternity and infant care services may come here any day for consultation and advice from a public health nurse.

In addition to the nursing services rendered to patients by nurses in these clinics, teaching sessions are held for medical students by the health officer and a public health nurse. Medical students spend a full month in the area, studying application of public health procedures in the community and the part played by the public health nurse in the promotion of health and prevention of disease.

The public health nurse as she goes about her work gives to the people in the community a sense of security which they would not have without her. It is interesting in going through the different neighborhoods to see how, from the child to the grandmother, each will approach the nurse for some word of advice or encouragement. A uniform is of the greatest value to her as she goes about her work. It seems to represent to the people who look to her for help all those things that they know she has to give them. In addition it affords a protection for the nurse herself who from time to time must pass through questionable neighborhoods on her rounds.

IN ORDER TO understand fully all aspects of the plan we have undertaken, it might be well to review briefly the types of service rendered by the Department of Health and by the Visiting Nurse Association.

The Health Department of the City of Greater New York has established 30 health districts throughout the 5 boroughs of Manhattan, Brooklyn, Queens, the Bronx, and Richmond. The objectives which prompted this districting were not only economy and efficiency of operation but also improvement of health care if given on a neighborhood basis. Each district has a health center administered by one health officer and as many nurses as may be deemed proper in proportion to the population of the area. The staff nurse in these clinics performs the usual duties of assisting the doctors, instructing the patients, keeping records, and interpreting physicians' findings. In addition to her responsibilities in the clinics the public health nurse assists the physician with physical examinations in the public schools, and in carrying out his instructions in some special health problem, may hold conferences with a child's parents and teacher to enlist their understanding and cooperation. She makes home visits in certain specified instances. In the case of the newborn infant she visits the home when the mother fails to bring the child in for physical examination or upon the recommendation of the physician in some special case. If the parents of the preschool child need instruction in regard to diet or health care, she visits the home. She must visit all patients ill at home with communicable disease in accordance with the regulations of the Sanitary Code. She goes also to discuss the need for dental work for the school child and for special care for the cardiac child. In tuberculosis and venereal disease, contacts must be examined and precautions outlined. Lastly, she checks all boarding homes for infants, visits midwives regularly, and may follow up complaints regarding improper sanitation in lieu of the health officer.

Under the auspices of the Visiting Nurse Association, bedside care is given in the homes under a doctor's orders to acutely and chronically ill persons. With the help of nutrition consultants the nurse also assists the family in planning meals when special diets have been prescribed by the physician. She is prepared to advise patients on nutritious foods, availability and costs. Maternity patients receive direction in feeding and clothing and general care of the baby for the first month after discharge from the hospital. Mothers' classes are given in district centers by nurses who discuss prenatal care, personal hygiene, mother's and baby's clothing, normal nutrition, baby's bath, and care of mother and baby after the baby is born. Special care, too, is given to orthopedic patients by nurses skilled in this field, both in the home and in the district centers. In the latter, training is given with equipment especially built to re-educate the muscles. Rehabilitation of the discharged veteran is included. As part of the services offered, the patient and family are guided by the nurse in the care to be given between visits and in the eventual taking over of the entire responsibility.

Nominal fees, based on costs, are charged

where the individual is able to meet them.

It is easy to see from the foregoing that under the present system even with carefully planned coordinated programs two nurses may visit one home for relatively the same purpose. For example, this summer the Visiting Nurse Association orthopedic nurse was in a home to give Kenny packs to a polio patient and met the Health Department nurse there reviewing isolation procedures. At another time a Visiting Nurse Association nurse was visiting the mother of a premature baby three weeks old to make sure the mother was following instructions for feeding and care. A Health Department nurse came in during the visit to discuss health supervision. Instances of this kind occur from time to time.

WHAT THEN are the initial steps necessary to working out definite plans for launching a streamlined public health nursing service? At the beginning, the director of the Bureau of Nursing of the Department of Health and the director of the Visiting Nurse Association of Brooklyn met to discuss the points that each believed should be covered in a joint agreement. These points were then fully reviewed and amplified at a later meeting which was attended by each director, her assistant, a member of the National Organization for Public Health Nursing, and the director of the Visiting Nurse Service of New York. As a result of this meeting the form of agreement we are now using as a guide in developing the program was drawn up.

The need for a temporary sponsoring committee became obvious early and it was logical to turn to the board of the Visiting Nurse Association for members who would serve with the two nursing directors on such a committee. The committee finally comprised the president of the board, the chairman of the Nursing Committee and two other members of the Nursing Committee appointed by her, and the directors of the two cooperating agencies. This committee elected its own chairman. It was decided to call the program the "Red Hook Community Nursing Service." After studying the agreement and discussing it, some of the difficulties that would have to be met became evident.* Most important appeared to be necessary adjustments in salaries and hours of work. The collection of fees was also considered at this time. It was soon apparent a division of responsibility between the lay and professional members of the sponsoring committee would be logical. The former could give the greatest assistance by soliciting medical support through the organization of a medical advisory committee for the project, laying the ground work for the organization of a general advisory committee, making plans for volunteer participation and for a public relations and publicity program. Plans for these organizational phases of the program follow.

In order to obtain guidance in the proper methods of approaching the medical profession and what representation should be sought for the Medical Advisory Committee, the Sponsoring Committee met with two members of the Visiting Nurse Association Medical Advisory Committee. After thorough discussion, it was decided that the Medical Advisory Committee for the project be composed of seven members chosen as follows: one designated by the Kings County Medical Society, one by the Long Island College of Medicine, a representative of the New York City Health Department, a member of the Visiting Nurse Association Medical Advisory Committee, and three practicing physicians from the Red Hook-Gowanus District who would be appointed by the South Brooklyn Medical Society. The desirability of approaching these groups with a request that they nominate their own representative to the committee does not need an explanation, I am sure. This committee will elect its own chairman at the first meeting.

Organization of the General Advisory Committee was not so simple. In the first place, the Sponsoring Committee felt it inadvisable to retain the term "advisory" in the committee title. So often an "advisory" committee dies on its feet from lack of initiative and responsibility. The need for making this group the active and policymaking body has become increasingly apparent. Therefore it was decided to call this committee (which, it is hoped, will function like a board) the Council for the Red Hook-Gowanus Community Nursing Program.

For the same reason it was further decided to restrict the membership to as small a number as practical—at least in the beginning—with later additions carefully made as the

*Hilbert, Hortense. "Administrative Problems," page 602 this issue.

need is indicated. The initial representation will include 7 ex-officio and 9 official members. The ex-officio members will be the Commissioner of Health of the City of New York, the chairman of the Board of the Visiting Nurse Association, the director of the Nursing Bureau of the New York City Department of Health, the director of the Visiting Nurse Association, the health officer in charge of the center with the two supervisors, one for the Health Department staff and one for the Visiting Nurse Association staff. The official members will be a member of the Health Department of the City of New York, the chairman of the Medical Advisory Committee for the program, two regional industrial representatives, a board member delegated by the Brooklyn Tuberculosis and Health Association, a representative from the Department of Education and one from the Department of Welfare, the chairman of the Visiting Nurse Association Red Hook Volunteer Auxiliary and, as a neutral public health nurse, the educational director of the Visiting Nurse Service of New York. It is hoped that these representatives of organized community activities will also be either residents of the area or very familiar with its psychology and its needs. Suggested names for the Council are to be gathered by the sponsoring committee and submitted to the president of the board of the Visiting Nurse Association, and to the Commissioner of Health, for their approval. When this has been secured, a proper personal approach will be made to each prospective member who will subsequently be officially invited to serve by a letter signed jointly by the Commissioner and by the president of the Visiting Nurse Association Board.

This Council will have as one of its first responsibilities the launching of the program. The first meeting will be called by a temporary chairman at which time the Council will elect its permanent chairman. Among other matters needing early attention by the Council are a volunteer program and a public relations and publicity program. What will be done in these matters is for the Council to decide but it may not be amiss to mention some points which merit their consideration.

A volunteer program should serve two purposes (1) to recruit volunteers and educate the public in regard to the Red Hook Community Nursing Service and (2) to train and supply women to assist in the clinics, schools, and later possibly in homes if the need is indicated. The logical head of such a program would be the already existing chairman of volunteers of the Visiting Nurse Association Red Hook Auxiliary. It is suggested that she appoint two subchairmen. One would be responsible for the recruiting of volunteers and for this purpose, all possible community contacts should be sought. Her committee, which would be known as the Public Relations Committee, should draw to it representatives from the churches, parent-teacher associations, Junior League, settlement house boards and other interested agencies. A number of these committee members would then be trained and be able to address neighborhood groups for the purpose of interpreting to them the services rendered by the joint nursing service, and of recruiting volunteers to assist the staff in the actual carrying out of these services. The second subchairman would work with the staff on the duties of such recruits, an orientation and educational plan for them, and the assignment of each one to the place where she could render the most satisfactory service. This committee would be the Committee on Volunteers.

A STRONG CAMPAIGN is needed to develop public understanding of the program. The actual details of administering this campaign will depend, of course, on local budgets and procedures. The general plan, however, would probably have the triple goal of (1) acquainting residents of the area with the services available (2) providing professional information for local doctors to prevent any misconception as to the function of the joint nursing service and (3) securing the active cooperation of all community organizations including hospitals, industries, and church, civic, and club groups.

TO ACHIEVE the initial organizational steps which we have just now covered has taken many meetings and considerable time spent in personal contacts and research. In order to draw up a joint agreement, it was necessary to hold three conferences. Since then the Sponsoring Committee has had seven meetings. The first of these was to acquaint the committee with the agreement, to appoint a chairman, and to discuss the most important points that should be covered. At the second meeting, the city nursing director was intro-

duced to the Committee and the points discussed with her. Guidance as to the proper approach to the medical profession was sought at the third meeting from members of the Visiting Nurse Association Medical Advisory Committee. The membership of the Medical Advisory Committee for the project, and the proper approach to the various medical associations, was carefully worked out. At the fourth meeting the membership of the Council, the proper method of appointing a chairman, and the best approach to prospective members was considered. The type of letter of invitation was also talked over. The fifth meeting dealt with the formation of certain special professional committees to work on uniforms, education, and records. It seemed at this time also that the two nursing directors might start to work on a service program for the joint undertaking. At the sixth meeting held further discussion was given to the membership of the Council and to the best way of securing the approval of the Commissioner of Health of the City of New York of Council members and the actual wording of the letter of invitation to these members. At the last meeting very thorough consideration was given to the Volunteer and Public Relations Programs. This included the membership of each committee and its responsibilities and also the manner in which printed material and newspaper releases should be handled.

In presenting to you the preliminary steps we have taken in getting this cooperative public health nursing service under way in our community, it is our hope that you may find not only something of interest in what we have undertaken but also some help in the initial problems of organization, if you are inaugurating such a plan in your community. We in turn hope to take from this meeting ideas which will enable us to develop our program more effectively. In this, as in any other joint effort, difficulties and obstacles will arise. In order to overcome them, both groups must enter into the undertaking in a spirit of complete cooperation with the knowledge that a middle ground can be found, if there is the will to see it, and with a firm belief in the importance of the final objective.

II. Administrative Problems

By HORTENSE HILBERT, R.N.

THE advantages to be gained from thoroughly coordinated nursing services must by now be apparent to all concerned with the organization and administration of public health nursing—not to mention the families and persons benefiting from this service. The reasons for coordinating are becoming more rather than less urgent, with continued shortage of public health nurses and greater expansion in public health and medical care programs.

Yet in the country as a whole we have been comparatively slow in putting into effect the ideas we have so long promulgated and the theories we have so glibly propounded. Ways and means of expediting coordination in communities of various kinds and sizes have not been tried or experimented with very extensively. We have been particularly slow in the large cities where the situation is infinitely more complicated; and in the east where habits of community and agency organization can be said to be most firmly entrenched. In the west and middlewest more seems to have been done in this respect, particularly in medium sized and smaller cities.

The story we have to tell today is certainly neither original nor new. This is not a final report of something already accomplished, but rather a progress report on something which has not yet gone very much beyond the planning stages. Our chief justi-

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fication for telling it is that it has been generally thought—in fact often said—that although combining or coordinating of public health nursing services among various agencies might be possible in smaller communities, it could probably not be attained in large cities.

On the assumption that what is good for people in general is also good for those living in large cities, even the largest, we in New York, are about to launch out upon a trial in a single area in one of our five boroughs. I am sure there have been moments in the lives of those of us directly preoccupied with the project when we have wished that we had never brought the whole thing up, and when it seemed like a pretty foolhardy proposition. However, for my own part these moments have been few and have been evoked by relatively trivial obstructions. The sincere desire to cooperate as intelligently and fully as possible has to date certainly been the predominating element in our joint enterprise. In this connection I wish to say that the specific suggestion of generalizing our services first came from the Brooklyn Visiting Nurse Association and antedated my coming to the Health Department.

A few general facts about our mutual aims may be brought out at this point:

First, there are only two agencies involved in this undertaking, which is not typical of all districts or boroughs of New York City. Although our choice was not thereby deliberately conditioned, it does present a simpler situation than would be encountered elsewhere in the city. In other words we are proceeding from the relatively simple to the much more complicated situations which obtain in certain sections of Manhattan, for instance, where many more agencies would be involved.

Second, there has never been any thought of administrative merger of the two agencies concerned. The pooling of services will be on the plane of direct service only. Personnel and finances will be separately administered, but under a joint plan and under the guidance of a local community council serving the whole.

Third, the very fact that we are at our most critical stage as far as nursing personnel is concerned has not discouraged but has rather encouraged us to proceed at this time. It seems the best possible reason for learning whether and how one group of nurses giving a truly general family health service can provide more and better service than two groups, each giving a portion, overlapping at some points and leaving uncovered spots at others.

Fourth, some assistance, probably financed from an outside source, in the way of an analyst—someone well qualified in public health nursing, with statistical training and the experience required for evaluating the joint service as it develops—will be required. Neither operating agency can afford to contribute this necessary adjunct to the demonstration. And there may be other points at which some aid from outside our respective operating budgets will be needed in order to bolster up the experiment at certain points.

Mrs. Dickson* has covered the aspects of the service which relate to preparation of the community. She has given you a description of the kind of community to be served and a birdseye view of the services now covered by both agencies.

It remains for me to enumerate some of the more practical details of an administrative nature which need to be negotiated in bringing about a coordination of nursing services between a health department and a visiting nurse service.

LOCAL ORGANIZATION OF NURSING PERSONNEL

The field nursing and supervisory personnel of both agencies assigned to the health center district will constitute a single pool of public health nurses, all of whom will have some administrative responsibility to the district health officer, as medical public health administrator of the district. Every public health nurse and supervisor, regardless of which agency employs her, will give all the kinds of nursing service required by both agencies.

Of the total number of field nurses to be assigned to the Red Hook Community Nursing Service, the ratio of Department of Health to visiting nurses will be approximately 2 to 1. The total number of public health

*Dickson, Mrs. Carroll J. "Preparing the Community," page 598 this issue.

field nurses to be assigned by both agencies will be around 45, or 1 public health nurse to approximately 3800 of the Red Hook-Gowanus population (which is about 180,000.) In addition the services of one practical nurse will be contributed by the Visiting Nurse Association of Brooklyn.

Based on 1 field supervisor to 8-10 field nurses, we will try to assign 5 field supervisors from the two agencies, of whom 2 will be contributed by the Visiting Nurse Association and 3 by the New York City Health Department.

Although the district supervising nurse assigned by the Department of Health to the Red Hook-Gowanus Health Center District will be administratively responsible for the total nursing service, a supervising nurse will in addition be assigned by the Visiting Nurse Association of Brooklyn to assist her in the administrative and educational phases of the joint service, and to act as liaison between the Visiting Nurse Association and the Red Hook Community Nursing Service.

Nursing and non-nursing consultants in special fields now employed on the staffs of both agencies will be available to the total public health nursing personnel of the Red Hook Community Nursing Service. These include: from the Department of Health, public health nursing consultants in tuberculosis, venereal disease, acute communicable disease, maternal and child health (midwives, foster homes, day care centers, and newborn nurseries), orthopedics, and school—and non-nursing consultants in nutrition and records and statistics; from the Brooklyn Visiting Nurse Association, public health nursing consultants in orthopedics and industrial hygiene—and non-nursing consultants in nutrition, records and statistics, and occupational therapy. Where both agencies engage a special consultant or consultants for the same fields, such as orthopedics and nutrition, their service to the Red Hook Community Nursing Service will be jointly planned and executed.

The ratio of clerical personnel, including stenographers, typists and others, to public health nursing personnel, will be about 1 to 5. Of the 10 clerks required for a total public health nursing field and supervisory staff of 51, approximately 3 will be provided by the Visiting Nurse Association, and 7 provided by the Department of Health.

HOUSING AND OTHER PHYSICAL FACILITIES

The staff of the Visiting Nurse Association serving the Red Hook-Gowanus area is already housed in the health center district of the New York City Department of Health, occupying adjoining quarters within the building. According to present arrangements, space, heat and light are furnished by the City Health Department for the Visiting Nurse Association quarters, and the Association furnishes its own cleaning, telephone, office furniture, and equipment.

After the two nursing staffs are joined it would seem feasible for the Department of Health to extend cleaning and telephone service to the space occupied by the whole community nursing service, perhaps in exchange for certain types of equipment, such as bags, needed for giving nursing care, which are not now furnished Health Department nurses.

PERSONNEL POLICIES

Salaries. There are differences in the beginning salaries paid nurses in the two agencies and also differences in the range of salary. For example, at present the range for public health nurses in the Health Department is $1,860 to $2,700 (including cost of living addition) and $1,960-$2,160 to $2,520 for the Visiting Nurse Association. When we first contemplated a joint service the discrepancy was greater—and we hope it will soon disappear altogether. As a matter of fact the difference in average salary is not very great. The problem of salary in my estimation does not now loom as large as several months ago. When we take into account longer hours of work in the voluntary agency, fewer holidays, et cetera, the salaries reduced to an hourly basis are already quite similar.

Hours of Work. The weekly hours of work in the Health Department are 38 (and even less in summer) as against 41 in the Visiting Nurse Association. There is also some difference in the distribution of hours throughout the week. Since Health Department nurses are part of a much larger group of departmental, and an even larger group of municipal employees, and are, therefore, governed by the same conditions of work as far

as hours, days leave of absence for vacation, illness, and other purposes, are concerned, not much flexibility can be expected. It is anticipated, however, that assignments can be scheduled within the framework of the combined staff in a way to maintain the number of hours if not the exact distribution now in effect for each staff. There is no appreciable difference in the number of days allowed for vacation and sick leave.

Uniforms, Nursing Bags, and Equipment. The same uniform appropriate for the various services comprising the generalized nursing program obviously should be worn by all nurses in the Red Hook Community Nursing Service. If the uniform bears insignia of any kind this should be of the Red Hook Community Nursing Service rather than that of either the Visiting Nurse Association or the Health Department.

No real uniform is now provided by the Health Department. A white apron and cap are worn by Health Department nurses in clinics and a light colored smock in schools, provided by the nurses themselves. The Visiting Nurse Association nurses wear an outdoor as well as an indoor uniform, both provided by the nurses. Nursing bags containing equipment needed for home nursing care of the sick as well as other types of services given in the field, not now provided by the Health Department, will be needed by every nurse in the Red Hook Community Nursing Service.

If it proves impossible to provide the Health Department nurses a uniform and bag of the kind already in use in the Visiting Nurse Association from official agency funds by the time we are ready to start the joint service, effort will be made to secure these from other sources. We believe it important that the nurses look as well as work alike as much as possible.

Transportation and Other Field Expenses. Expenditures for transportation by public carrier and field telephone calls will continue to be supplied by the two agencies for the personnel on their respective payrolls pending further study of the most equitable distribution of such costs.

Provisions for the Health of the Staff. The Municipal Civil Service Commission requirements of pre-employment medical examination given by the Commission's own medical staff apply to the nursing personnel of the New York City Department of Health. At the time of appointment to the Department a chest x-ray and examination are required and a medical examination by a physician employed by the Department. No periodic examinations are required thereafter.

In case of absence of 30 days or more, personnel is referred routinely to the Board of Physicians in the Department of Health. Personnel may also be referred to this Board for other health conditions relating to the job.

The Brooklyn Visiting Nurse Association requires a complete pre-employment and annual health examination by a physician selected by the Association. One-fourth of the expense of these examinations is borne by the individual nurse and three-fourths by the agency. After the age of 40, a chest x-ray is required only every other year.

We would like to and believe it entirely possible to incorporate the best features of both plans, the Health Department making its present facilities available to all staff members of the Red Hook Community Nursing Service and extending to its personnel the pre-employment and periodical health examinations already required by the Visiting Nurse Association.

Staff Council. Each of the two agencies already has a staff council. The local staff council of the Red Hook Community Nursing Service will have a representative on the central councils of both agencies, each reporting back to the whole Red Hook Community Nursing Service.

Staff Meetings. Monthly staff meetings of the total nursing personnel will be conducted by the district supervising nurse and the assistant assigned by the Visiting Nurse Association. More frequent staff conferences will be planned and conducted by each field supervisor for the nurses under her direct supervision. The joint use of consultants in special fields of both agencies are also part of the in-service education plan.

Supervising nurses of the two agencies will attend the Central Office staff meetings of their respective agencies and bring back reports to the total nursing staff at the time of the local monthly staff meetings.

In-Service Education Programs. The in-service education program will be planned

for the joint staff on the basis of combined needs and will be carried out in the Red Hook-Gowanus Health Center District by the nursing supervisors assigned by both agencies.

Stipends for further study we believe should be made available from public and private funds to all nurses of the Red Hook Community Nursing Service, regardless of the source of their salary. From public funds, scholarships are available through Title VI of the Social Security Act for study in general public health, tuberculosis, and venereal disease and through Title V for study in maternal and child health and orthopedics; and from private funds, from the National Tuberculosis Association, National Infantile Paralysis Foundation, and the Brooklyn Visiting Nurse Association.

Evaluation of Public Health Nursing Performance. Evaluations of Health Department personnel are submitted periodically in connection with ratings required by the Municipal Civil Service Commission. Evaluation report forms, intervals, and other matters relating to evaluations will be jointly decided upon, and policies and practices for the Red Hook Community Nursing Service staff will be uniform between the agencies involved.

MANUALS OF PROCEDURE

A separate loose leaf manual of Procedures and Policies for the Red Hook Community Nursing Service will be compiled, combining needed materials from both agencies. Since no nursing manuals now exist for many of the Health Department services and others need to be revised, this will be in the nature of a new project.

SERVICE RECORDS AND ACTIVITY REPORTS

A general family service record which will provide for recording of all nursing service given by the personnel of the Red Hook Community Nursing Service will be introduced experimentally. This record form will be devised through a joint working committee of the Bureau of Nursing of the Department of Health and the Visiting Nurse Association of Brooklyn. The difficulty here will be to continue the recording and reporting for both agencies in a way to provide the data each of them needs for the whole borough or city at the same time that local experimentation with a joint general record goes on.

BUDGET PLANNING

The Visiting Nurse Association and the Bureau of Nursing of the New York City Department of Health will each work out a budget for its share of the service according to conditions previously outlined. These should be jointly reviewed by the Advisory Committee to the Red Hook Community Nursing Service before being submitted for approval to the governing bodies of the respective agencies.

FEES FOR SERVICE AND COST ACCOUNTING

This item has in New York City constituted one of the biggest "snags" to date. Fees for service are, as is usual with agencies of this type, received by the Visiting Nurse Association from those who can pay some or all of the costs, the fee being based upon the actual cost of the visit. The Department of Health receives no fees for any type of nursing service. Through the pooling of field nursing staff of both agencies, Health Department nurses will of course also be rendering service for which it is customary for the Visiting Nurse Association to receive a fee. Fees thus collected by all of the field nurses in the Red Hook Community Nursing Service will accrue to the Visiting Nurse Association, since their nurses will be contributing in the way of Health Department services at least the equivalent in nursing time of that contributed by Health Department nurses in the way of Visiting Nurse Association services. Every nurse in the Red Hook Community Nursing Service should have the same responsibility for collecting fees at the time nursing care is given for which a fee is collectible. However, there is every indication that actual acceptance of a fee by an employee of the municipal government in New York City will not be legally possible at the present time. Other means will therefore have to be devised for actual collection for services given by Health Department nurses.

As everyone knows who has had experience with fee collections, billing by mail has not proved practicable. Whether or not

the practice of having any nurse who gives the service also collect the fee is desirable in any case, is of course debatable. The fact remains that it is established practice in Visiting Nurse Associations. However, we do not intend to let this complication stand in the way of proceeding with a coordinated service, and we are convinced that a method of collection can and will be found.

Cost accounting and bookkeeping related to collection of fees for service to individuals or through contracts with insurance companies, industries, and other sources, will under the circumstances naturally remain the responsibility of the Visiting Nurse Association.

STUDENT PROGRAMS

No public health nursing students will be assigned to the Red Hook Community Nursing Service until it has been in effect for at least one year. Visitors will be limited in number and accepted only upon common consent. Commitments for medical students already made by either or both agencies will be kept.

So far I have touched upon some of the more concrete practical details of an administrative nature which have to be faced, some more ready of solution than others, but all of them soluble.

Some other less tangible factors enter into the situation which must also be faced realistically and frankly. These may prove more obstructive to coordination than the organizational and administrative factors already noted. They have to do with attitudes of workers and established habits of work. There are always employees in every agency who see a threat to security in a change from the familiar to the unfamiliar. This is also true of some public health nurses. Nurses who have for many years not given nursing care to the sick may feel a lack of assurance in their ability to do so. Others who have never liked bedside nursing, are frank to say that they have chosen Health Department work to avoid it. Still others resist what they consider the greater physical labor involved in this kind of service—and so on!

All of these factors if prevalent enough result in a sort of boycott of new ideas and methods. Such attitudes are highly communicable. Although I do not wish to exaggerate these phenomena, they have definitely to be reckoned with. The best immunization against them is a completely democratic approach, giving all members of the staff every opportunity to become thoroughly familiar with all the reasons for and against the plan by discussing them freely; and having individual choice regarding participation.

This we are trying to provide. Unless the nurse participating in the experiment wants to because she sees it as an advanced step in public health nursing and good for the community she won't be good for the job. Neither will she have the personal, professional satisfactions so necessary for contributing fully and intelligently to any service. In our own agency we have asked for volunteers first from among the nurses already in the Red Hook Center, and then from the whole staff. Although I hardly feel qualified to speak for the Visiting Nurse Association I can well imagine that there may be similar reluctances among visiting nurses to associate themselves with our kinds of services and working conditions. As you know, health departments in general have the reputation of being pretty hard-boiled and lacking in some of the graces and refinements that have come to be associated with private agencies.

But, speaking eugenically, we may provide through this union a hybrid which by retaining and strengthening the best characteristics and by breeding out the defects and deficiencies of each result in a superior public health nursing service to the community.

The papers by Mrs. Dickson and Miss Hilbert were presented at the NOPHN general session, "Organizing the Community for Public Health Nursing," Biennial Convention, Atlantic City, N. J., September 23, 1946.

The Voluntary Nursing Agency

By C.-E. A. WINSLOW, Dr.P.H.

THERE ARE few things more exciting than the vitality of an idea. A pioneer in dealing with the problems of a slum district in Liverpool conceives the possibility of a new type of service. The idea works. It is taken up in New York and bears fruit in the form of a new profession enlisting the efforts of thousands of devoted women; and its repercussions extend to the field of education and lead to new independent schools of our greatest universities. It spreads to Finland and Czechoslovakia and Brazil and the Argentine. The echo passes from one land to another; but it does not die out and become fainter as most echoes do. It strengthens and deepens with each repercussion. For the idea itself is alive.

Such a germinal idea is that of public health nursing. One of the ablest expressions of that idea has recently come to my desk from the island of Jamaica.[1] Dr. Rolla B. Hill, director of the Public Health Training Station at Jamaica, sums up the case as follows:

> The public health nurse is an essential, if not the most essential part of the team of specialists, which go to make up the public health department of a nation, a parish, or a city. Included in this team are the public health officer, the epidemiologist, the bacteriologist, the vital statistician, the health educator, the sanitary engineer, the various medical specialists in child welfare, malaria, tuberculosis, and the venereal diseases, and the sanitary inspector. All of these workers are important and necessary but the public health nurse, either alone or in association with the other members of the team, takes part in practically all aspects of health work. She is the link between the other workers and the home and family, carrying out orders, giving advice and assistance in the home, apprizing her co-workers of conditions to be remedied, and in general carrying the message of health down to the ultimate unit, the individual.

We are accustomed to trace the history of the profession of public health nursing back to the broad vision of Florence Nightingale and, in particular, to the establishment of home nursing service by William Rathbone in Liverpool in 1859. This was, in fact, the first organization to provide the service of salaried nurses under lay auspices. But Hill justly points out that the real pioneers in this field were the Benedictine monks of Monte Cassino (dating back to the Sixth Century), the various nursing orders of nuns, the order of St. John of Jerusalem (following the Crusades), the Nursing Sisters of Devonshire Square, established by Elizabeth Fry, and the various nursing orders developed by the Anglican Church.

The most significant change which has taken place in the history of this evolving profession has been the shift from primary preoccupation with the care of the suffering to a broader conception of the community nurse as—in equal degree—a teacher of the positive gospel of health. Florence Nightingale expressed this ideal of the nurse as a Missioner of Health; but it came to full fruition in the United States toward the end of the nineteenth century with the formation of our first broadly conceived community nursing groups at Buffalo and elsewhere. I have always regretted that the Boston group changed its original name of the "Instructive District Nursing Association." In the earlier decades of the twentieth century, associations with the dual objective of caring for the sick and training for health grew up in most of the large cities and many of the smaller cities in the United States.

Nothing is static in the ever-changing flux of life; new objectives and new emphases arise with the progress of health science and with far-reaching changes in the actual health problems of the community. Thus, the work of the public health nurse has expanded during the past quarter-century to include intensive developments in the fields of maternal and infant health and the control of tuberculosis and

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the venereal diseases. I look for a further broadening of our concepts in regard to child health. In the past, "we have cut off separate segments of the child's life, health, education, recreation and the like; but we have done little in the way of planning for the child as a total individual. I trust that in the future we shall create on local, state and national levels, councils on child development, in which doctors and dentists, nurses and health officers, psychologists and psychiatrists, educators and recreation experts, social scientists and welfare officers, will plan together for the intelligent cultivation of that most precious of all crops, the child of tomorrow."[2] Such a program has recently been initiated by the New Haven Visiting Nurse Association.

The other extreme of the human life span presents a challenge of equal importance—and one which has received far less concrete recognition than it deserves. The living organism is most vulnerable at the beginning and the end of its course; and our success in controlling the communicable diseases of infancy and childhood and early adult life has caused a lengthening of the life span which greatly increases the relative importance of the diseases of later years. The mean age of death of the American population is now 65 years; and about half of all deaths are now chargeable to diseases of the heart and arteries, nephritis, and cancer.

It is such diseases which will year by year demand an increasing proportion of the time of the public health nurse. Many of these conditions are of long duration and for a considerable part of their course may be cared for in the home. How far are the specialized techniques for the nursing of such diseases and the progressive evolution of such techniques being interpreted to the public health nurse in the field? Every large visiting nurse association has specialized supervisors or consultants in maternal and child health, in tuberculosis, in venereal disease control. How many have specialized supervision and expert leadership in the nursing care of heart disease, or cancer, or diabetes? Perhaps some of the large sums now available for the fight against cancer could be profitably utilized in developing services of this kind.[2]

IN ALL THE AREAS of public health nursing, there are three emphases which are of fundamental and increasing importance—those relating to nutrition, to mental hygiene, and to social service. Every year, more and more evidence accumulates as to the existence of widespread subclinical but serious difficulties, due to the lack of specific factors in the diet. Problems of mental hygiene are omnipresent in the nurse's work. In earlier days, we often heard a hospital superintendent say, "We don't admit mental patients." He was in error. Except for the occasional wealthy operation addict, every patient admitted to a hospital is in some degree a mental case. Illness in the home inevitably produces emotional stresses, both for the patient and for the family; and the success of the nurse depends very largely on her comprehension of such problems.

The public health nurse is not a trained social worker and the claim of nurses to dominate in this field has worked serious harm in certain communities. Yet she must be familiar with the resources of the community when expert social counselling in this field is needed; and in rural areas where no social worker is available, she must do her best to cope with social problems as they arise.

It is obvious that the expanding program of public health nursing involves increasing demands upon the nurses upon whom the task of carrying out those programs rests. It is particularly gratifying, therefore, that this meeting brings together not only board members of visiting nurse associations but also those board members responsible for the conduct of schools of nursing. The older concept of apprenticeship training is no more adequate in nursing than in any other profession. "Learning by Doing" is an important principle; but the emphasis should be on "Learning." Mere "Doing" may often be a de-educational process. Performance of routine hospital duties harks back to the educational methods of Mr. Squeers at Dotheboys Hall.

The nurse of today must still be manually competent to make a bed and give a bath. It is equally important that she should have—in her basic training—a solid conception of the chemical and biological sciences which underlie the practice of her profession and the content of her teaching. Furthermore, since she is to be a teacher, and since the application of the principles of mental hygiene is a major element in her daily tasks, she must be given a concept of the principles of psychology and of the emotional motivations which determine human conduct. Finally, she must at least—even in her undergraduate

course—be introduced to the sciences which deal with man in society and with the social machinery of the modern community, with which the healing arts are so intricately involved.

This means that any training school worthy of the name must require its independent educational budget and its faculty of competent teachers, having adequate time for study and self-improvement, as well as for direct pedagogic duties. It must have a program carefully mapped out so as to attain maximum educational objectives in the time allotted. It must select its entering students with care and discrimination; and it must leave them sufficiently free from routine hospital service so that they may be truly educated and not merely trained.

The public health nurse must superimpose upon her basic course, suitable postgraduate work in her special field, as outlined by the NOPHN and the APHA. And again, the selective process must come in. Many an excellent hospital bedside nurse would not function effectively in the tasks of public health nursing. To quote once more the voice from Jamaica, Dr. Hill rightly says that the public health nurse must "have initiative, be ready to take responsibility and be tactful and friendly, and at the same time have sufficient social and educational background to be a leader in her district, and make the people trust and look up to her. And she must have sufficient character to be true to the trust reposed in her. It is easy to do routine work, but it is not easy to rise above the daily routine and do creative work. The ability to do this distinguishes the outstanding from the merely acceptable nurse."

The attainment of such a goal clearly demands not only sound basic nursing training and a good course in public health nursing but also a comprehensive and continuing program of staff education such as our leading visiting nurse associations have planned and carried out. Only by such in-service education, can the nurse proceed to an even more intelligent and sensitive handling of the complex problems of human behavior.

I would urge upon you, as Board Members, that while your primary problem is to plan, with the advice of your director, a modern and efficient public health nursing program, you have also another and a wider obligation. You have the responsibility—as leaders in your community—to see that the background for such a program is provided. Let me cite three major problems with which you should concern yourselves as citizens.

THE FIRST OF THESE problems is that of the provision of adequate facilities for the institutional care of convalescent and of chronic illness. There are few areas in which our community machinery is weaker than in the provision of resources of this kind. In these two distinct, but related fields, thousands of patients are kept in general hospitals when they could be more economically treated in institutions of a simpler type; and tens of thousands are discharged from general hospitals to homes where they cannot receive the care they need. Your organizations are in the front line of the war against disease and when you sense the need for changes in the major community strategy which underlies and conditions your work, you are in a position to exert a powerful influence for bringing such changes to pass. The visiting nurse association should provide adequately for the care of those cases of convalescence and chronic disease which can best be cared for in the home; but it should also take the lead in securing suitable facilities for those who do not need the service of a general hospital but who do require a type of care which cannot be provided in the home.

A second topic with which Board Members should be seriously concerned is that of housing. A prominent physician of Liverpool in the days of Rathbone objected to the first experiment in public health nursing on the following grounds: "It is evident," he said, "that the essential conditions of rational and successful sick nursing such as good air, light, bedding, good food, et cetera, are altogether wanting in the homes of the poor. Of what use is the giving of medicines when everything else is lacking? It is not that the nurses shrink from the privations and injurious influences existing in the cottages and hovels, but it is the impossibility of being useful under such circumstances that renders home nursing unattainable for the poor. They cannot be nursed and healed there." We have made much progress since 1859. It is still true, however, as every public health nurse will testify, that the slums of our cities and the

shacks on our Appalachian mountain sides provide grave handicaps in the nursing of the sick. You, as Board Members, should concern yourselves actively with the one possible solution of this problem, the continuation and expansion of the federal housing program. This program for housing low-income families (with family income under $1500) is embodied in the Wagner-Ellender-Taft bill which passed the Senate in the spring but was smothered by cloak and dagger technics in the Banking and Currency Committee of the House. This measure deserves the active and insistent support of everyone who is dedicated to the cause of public health.

THE THIRD MAJOR ISSUE in the background of the health movement is that of medical care. Here, you will have to be discreet and to move with caution in view of the regrettable opposition of the official leaders of the American Medical Association. Do not forget, however, that the existing evils are most grave. With the finest medical resources in the world, the lower half of our population, from an economic standpoint—receives less than half the medical care it needs. Only in the very high income brackets are the precious gifts of modern medical science being actually delivered to the American people. Furthermore, there are only two procedures by which this condition has ever been remedied in any country. One of these is State Medicine, practised in the Soviet Union as we practice State Education in this country—a solution advocated by no considerable group in the United States. The other possible procedure is compulsory health insurance which is before Congress in the form of the Wagner-Murray-Dingell Bill. The broad principles of this bill are in close accord with policies adopted officially by the American Public Health Association and the National Organization for Public Health Nursing. They should receive your thoughtful and dispassionate study, and deserve your support—in so far as such support will not handicap your associations in their local public relations with the medical profession.

You will note that, in addressing you, this afternoon, I am conforming strictly to the traditions set for speakers on such an occasion. I am assuming that both the nurse and the board member are paragons of all the virtues, instilled with devotion and knowledge and statesmanship, understanding all the sciences and practising nearly all the arts. So far as board members are concerned, I can at least speak with authority since I have been married to one for nearly forty years.

DURING THE PAST YEAR, both board and staff have been provided with a valuable new instrument which will be of the greatest assistance in the performance of these herculean tasks. This is the report on the voluntary health agencies by S. M. Gunn and P. S. Platt recently published by the National Health Council.[3] This small volume deals with two major topics—the management of the individual agency and the relation of the various voluntary agencies to each other. So far as the promotion of the efficiency of the individual agency is concerned, the Gunn-Platt report applies quite directly to the work of the organizations which this gathering represents. It contains not only a systematic analysis of the functions of a voluntary agency but a series of direct and suggestive questionnaires by which the work of a particular agency may be subjected to self-evaluation. All over the country, alert public health nursing organizations are using these schedules to appraise their own activities, dividing them among small committees for intensive study and reporting back for full discussion to the board and the staff as a whole.

The report raises such questions as the following. What is the actual program of your organization and how fully is it related in balance to the actual needs and the actual psychology of your community? How is your program related to the work of other official and voluntary health agencies in that community? What duplications exist and what gaps remain to be filled? Is your board really representative of all the elements which should be vitally interested in its program? Is there dead wood on the board? Is the term of membership too short or too long? Are the board meetings conducted with efficiency, but also in such a way as to foster constructive group thinking? What are the essential considerations in the recruitment of your staff and how far are those considerations actually met? Is your program of in-service staff training adequate and effective? Have you a formal plan of education for board members as well as for staff? Are the conditions of work of the staff such as to

promote the highest quality of service? Are salaries adequate, are the hours of work reasonable, have you a sound retirement and pension system in operation? (I know of one organization which has spent many profitable hours on the question of the suitable retirement age and how to utilize the services of the nurse who, before reaching that age, is unable to perform the arduous tasks of the full-time field nurse). Is the nurse relieved of all possible routine non-professional tasks by the provision of essential clerical assistance? What are the exact functions of non-nursing members of the staff? What progress has been made in the utilization of volunteers and in training them for the important assistance they may render? How nearly adequate is the budget of your association and how may it be increased? How far can part-pay and full-pay service and service to industrial firms be developed? How sound is the accounting system and the business management of the corporation for which you are responsible to the public? Are the physical facilities of your headquarters and your district stations such as to promote efficiency and maintain standards of reasonable amenity? How fully—and consistently—is the work of your organization interpreted to the community which it serves and to the agencies and individuals from which its financial support is derived?

The boards of directors of voluntary visiting nurse associations are responsible for the expenditure of 15 million dollars of funds contributed in the main by private generosity. You have a very grave responsibility upon your shoulders. You can discharge that responsibility only by attending meetings, by maintaining contact with the national health organizations, and—in particular—by utilizing to the full the resources of leadership which can be provided by a well staffed and progressive state department of health. In the broader health field the 20,000 members of your boards throughout the country can exert a powerful influence in securing good health departments, facilities for chronic and convalescent care, and the other background essentials of the public health program.

The second general theme of the Gunn-Platt report is the relation between various voluntary agencies, as distinct from the efficiency of the individual agency itself. In this connection, the report is primarily concerned with lack of coordination in fund-raising and in actual service between the various voluntary groups established to arouse interest in particular diseases, such as tuberculosis, cancer, infantile paralysis, venereal diseases, mental diseases, and the like. And it urges experimental approaches to a unified program on local and state levels and progress toward combined efforts at fund-raising, particularly by those agencies now deficient in financial resources.

This part of the report is not so directly applicable to the public health nursing organization. Your groups have been formed not for propaganda in respect to a particular disease but for actual service in respect to the general nursing problems of community health. Your problems of relationship are not primarily with the National Tuberculosis Association or the National Foundation for Infantile Paralysis. They arise in connection with other service organizations in the field of community nursing—and particularly with those maintained by the official health agencies.

WE HAVE ALREADY made much progress toward coordination of this kind. Twenty years ago, it was not unusual to find half a dozen or more different groups of nurses in the field. A single family might theoretically be visited by nurses from the board of health, the board of education, the visiting nurse association, the local tuberculosis association, the child welfare society, the maternity health association, and the crippled children's aid society. Today, most of the smaller organizations have been merged; and the general picture is one in which only the board of health nurses, the school nurses, and the voluntary visiting nurses function—with two or all three of these combined in many areas.

The problem is, however, only partly solved. Its full solution, I think, will be a major challenge to the statesmanship of your organizations during the coming decade. There is no simple, or easy, or uniform answer.

I believe, however, that two general principles should govern your decisions in the matter. First, it seems clear—from the standpoint of efficient and sympathetic service to the individual family—that we should approach as far as possible the ultimate ideal of a single field nurse providing for a population group of not over 2,000 persons, a com-

plete generalized service, including both health guidance and bedside care. But—second—it is equally clear that the guidance of community nursing service by voluntary boards has proved of inestimable value and that this value should be preserved in our program for the future.

There are many procedures by which this apparent conflict of two desirable ideals can be solved. In a rural community, one nurse, employed by the visiting nurse association can serve both the board of health and the board of education. In a moderate sized city, the board of health may pay the VNA to perform special nursing services such as maternal and child health work and tuberculosis nursing. School nursing may be done by the board of health. The board of health may take over the entire community nursing program, including bedside care as well as instructive service. A joint service may be set up on a plan which operates under the direction of the health officer but maintains the VNA board with advisory powers, made actually effective by agreement between the two contracting parties. All these—and many other devices—have been tried in practice and in some instances with highly encouraging results.[4]

Again, let me repeat that the problem is not one of easy or uniform solution. No cooperation can work if the health officer, or the commissioner of education, or the director of the VNA lacks the instinct and the restraint necessary for such cooperation. Autocratic health officers and autocratic nursing directors are not unknown to science. In many communities the salary scales and the professional standards of the official and the voluntary agency are so divergent as to make cooperative effort difficult or impossible. All that you can do is to study the experiments made at Dayton and Columbus, at Oakland and Seattle, at New Haven and New Orleans; to note their failures and their successes; to analyze the policies of your local organizations and the psychology of their leaders; and then to take such tentative steps as seem possible toward the goal of more completely generalized district service. In a recent survey of the Metropolitan District of Washington, D.C., three different solutions were suggested for certain of the six political jurisdictions involved.

It seems to me, however, most essential that —in any solution of this problem—the unique values of the voluntary health agency should be preserved. In my judgment, the voluntary hospital and the voluntary nursing organization are not merely temporary features of American social life, demonstrations, to be turned over without reservation to the official agencies. They have come to stay.

IN PARTICULAR, the organizations such as are represented at this meeting have made—and should continue to make—contributions of superlative value. It is difficult to exaggerate the importance of the achievements in the field of board member organization since the first Board Members Conference was held in New Haven in 1927. The evolution of the Board Members Section of the NOPHN and of the corresponding sections of state nursing groups, board members' contributions to PUBLIC HEALTH NURSING, the *Board Members Manual,* the group study of the Gunn-Platt report now being made by board members throughout the Nation—these represent a mobilization of board member interest and progress in the preparation of Board members for intelligent public service which is of incalculable social value. In no other area have the members of voluntary boards of directors so fully realized the responsibility of seriously preparing themselves for the discharge of the duties which they have freely assumed for the common good.

The significance of your achievements extends beyond the specific field of public health nursing. It strikes at the heart of one of the most fundamental problems in the philosophy of society. The basic issue before the world today is a proper balance between the two essential factors of individual freedom and initiative on the one hand and cooperative planning on the other. Unless we can find a sound middle course between the extreme poles of chaotic individualism and autocratic statism, the future is dark.

Our press and our more serious publications echo with the conflict between proponents of the two extreme viewpoints. The July issue of *Harper's Magazine,* for example, has three articles dealing with this issue. On one side, Bernard De Voto concludes that "after a year of peace private enterprise is superb in the advertising section but its station wagons are only pictures, its fountain pens are correctly classified by the Treasury Department as

jewelry and its pants are no damn good." On the other side, C. Hartley Gratton writes with doleful despair of the program of the British Labor Party; and J. H. Spiegelman pours scorn on "Harold Laski, Barbara Wootton and Herbert Finer, and those others who welcome the ever increasing involvement of society in government in the simple faith that somehow government will know just what to do, will be able to do it, and will always want to do it."

Both these opposite positions are extreme and dangerous. The initiative of Individualism may not have proved as "rugged" as we had hoped during the past twelve months; but such initiative has its supreme and essential values, which must be preserved if society is not to degenerate into a lifeless machine. The essence of life is change and progress. On the other hand, Spiegelman's sarcasm is equally unjustified. No one has ever advanced such a faith in society as he attributes to the writers whom he criticises; but even such a belief would be sophisticated by comparison with the even more naïve faith that if we leave everything alone and everybody fights for his own financial interests and power, some divine force of nature will make everything come out well in the end.

The driving force in the society of the future must be free, individual human initiative. But freedom in this sense, represents only the possibility of a good life—not its realization. Freedom must be combined with a vital sense of social responsibility and with a realization that in the complex mechanized world society in which we live, sound cooperative planning for the common good is essential—not only for progress but for survival.

It appears to me that the history of board member organization during the past twenty years is a perfect example of the way in which this basic problem can be solved. You are free men and women who have devoted your time and energies without remuneration to the service of mankind; and you have prepared yourself by formal processes of self-education for the adequate technical performance of your tasks. In your instinctive philosophy, the streams of individual initiative and of cooperative social planning have mingled in fruitful harmony. Your achievements offer a model and an inspiration for social progress in wider fields of national progress and world coordination.

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Nursing Observation of the Infant

By MARY MACDONALD, R.N.

THE NURSE is frequently and intimately associated with the infant and can play a stellar role in any program directed toward the early discovery of congenital orthopedic defects. That such crippling conditions respond more readily to treatment, if discovered in the early months of life, is an accepted fact. Too frequently, however, recognition is postponed until the deviation from normal becomes a fixed deformity complicated by secondary disabilities; as a result, treatment is technically more involved, more time consuming, and, of course, considerably more expensive. In addition, delayed recognition exaggerates the psychological trauma which may result from circumstances that set a child a little apart from his playmates. Nurses seem to vary in their ability to recognize atypical body alignment in the infant. Probably the nurse's native observational equipment, her past experiences, her interest in orthopedics, and her knowledge of normal motor development are the determining factors in her record of success or failure in this particular skill.

It should be emphasized, at this point, that the nurse must avoid any semblance of diagnosing. If a physician is not in attendance, the major objective is medical referral since no rehabilitation project is a success unless based upon sound medical treatment. If a physician is in attendance, the nurse reports to him the signs and symptoms indicative of a departure from normal. All physicians are profoundly appreciative of such reports; they realize fully that the nurse's opportunities for detecting such deviations are greater than are those of the average medical practitioner. She is present at home and hospital deliveries; she gives postnatal care; she shows the mother how to bathe her baby either in the hospital or on the mother's return to her home; she is an active participant at well-baby clinics, and makes health supervision visits to the home. The alert public health nurse scans each baby in his carriage as she walks by on her way to another patient. The author recalls at least three babies whose mild club feet were recently identified in this way. As the visiting nurse gives care in the home to the acutely ill or chronic patient, she invariably meets all the new very young additions, not only of the immediate family, but of the more general family group. Nursery school and school visits also offer rich opportunities for recognition of the more crystallized orthopedic handicap.

Observation of the infant should be considered in relation to the socioeconomic background of the family; the medical history of the family, especially when a history of hereditary or transmissible diseases or defects is known; the prenatal history, and the birth and immediate postnatal history. Observation of the baby as soon after birth as possible assures us that the upper respiratory tract is clear, the color of the skin good, the cry vigorous, and respiration well established. The condition of the mouth and gums, the eyes and ears, and external genitalia should also be observed carefully. Inspection of musculature for lack of tone or signs of weakness, such as hernias, should be made. The emphasis in this article is upon observation of signs and symptoms of congenital defects and birth injuries because nurses as a whole are less familiar with these aspects.

SINCE MOST BABIES in the early weeks of life are at one time or another bathed by a professional nurse, and since the bath is an opportunity for becoming unusually well acquainted with the infant, we are going to describe how the nurse may utilize this opportunity to uncover atypical postural alignment. First, we should review rather briefly our con-

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cept of normal infant posture. As the three-weeks-old infant lies, quietly (this is rare), supine, on a table (Figure 1) we observe that his head tends to be round and probably the most unwieldy section of his body; that he holds it to a preferred side except while crying, when it assumes the midline position; that any effort to change his head from this preferred side meets with stout emotional resistance from him. We note, too, a tendency of the trunk to lean toward the same side. (At three months he usually loses this decided preference for rotation of the head and trunk to either right or left.) When we look at his upper extremities, we see that the arm to which the head is turned is usually in a position of some extension and that the opposite arm may be rather sharply flexed at the elbow; his fingers are rather tightly curled and he uses his thumb as he does his fingers; his skill in thumb opposition does not develop until he is about ten months. The rib cage is rather narrow, in contrast to the abdomen, which is definitely protuberant, especially after feeding. His lower extremities are in positions of flexion and outward rotation at the hips; his knees are in some flexion also. His feet are freely movable in all directions; there may be a slight tendency toward supination and a long heel cord.

If we turn our infant over on his face, he may lift his head for a few minutes but he usually lies with it rotated to the preferred side. (Figure 2). His spine has two curves—dorsal and sacral—which are convex posteriorly. His hips tend again toward positions of flexion and outward rotation; they are usually tucked or drawn up under his lower trunk, making the buttocks high. In the prone position, his knees still lean toward flexion and his feet are turned out, in a valgus position.

As we look at any wide awake infant, we are impressed with his desire for free more or less purposeless movements. Except when he is asleep his posture is static only for brief moments. The intensity of his movements seems to be influenced by his emotional equilibrium. When keyed up either from anticipation or frustration, he indulges in violent, vigorous movements of the lower extremities and slashing movements of the upper extremities. A normally happy baby keeps moving and if he is in the prone position, he is apt to crawl away. While photographing the model baby in Figure 1 and Figure 2 we found it necessary more than once to return her to her original position.

AS THE NURSE bathes the baby, she considers each body segment individually as well as its relation to the whole body structure; she also keeps in mind deviations from normal which may be present in the segment in the face of a specific congenital defect. Discussion of the more long range nursing responsibilities is purposely restricted in this article because other sources cover this angle very adequately.[7, 18]

In bathing the baby's head, the nurse notes the occipitofrontal circumference. Routine steel tape measurements are sometimes taken 24 to 48 hours after birth; scalp edema due to trauma at birth has usually subsided by that time except when cephalematoma is present. The circumference is checked in relation to the length of the baby; the average is one half the length plus 3.9 inches.[6] Variations are noted and reported to the physician.

Although the baby chooses to lie with his head to a preferred side, no mechanical difficulty should be experienced in passively flexing his head toward the right or left. The nurse should be able to flex the head sufficiently to the right so the right ear rests on the right shoulder, or, if she flexes toward the left, the left ear should rest on the left shoulder. (In carrying out this procedure, the shoulder is immobile.) When the head assumes the midline position in crying, the ears should be equally distant from the shoulders, and the chin should be directly over the jugular notch. The head should give an impression of good balance; in other words, the sternocleidomastoids should pull smoothly and equally from both sides. The nurse reports to the physician any habitual flexion of the head to one side with an accompanying rotation of the chin to the opposite side. A torticollis may be caused by a hematoma on the affected sternocleidomastoid. If, in the course of bathing the neck, each sternocleidomastoid is traced from its origin to its insertion, the nurse may locate the small hematoma or its scar. Babies can simulate a torticollis for temporary periods, so the nurse should ascertain, before reporting to the physician, whether the noted abnormal position is habitual. Pain from an excoriated area in the folds of the neck may make the baby assume abnormal head posture.

Figure 1. Three weeks' old infant lies supine.

Figure 2. Head usually rotates to preferred side.

As the nurse bathes the baby's face, she may observe that the pupils of the eyes fail to react equally to light. Inequality of pupils is of importance clinically if an obstetrical palsy is present.[15] When the baby cries, the facial muscles should contract symmetrically. Failure to close one eye as tightly as the other, or inequality of activity in the cheeks may mean a facial paralysis. Since the sucking reflex is well established at birth, any sucking difficulties may idicate tongue tie, immaturity or other abnormal condition such as intracranial lesions. Harelip and cleft palate cannot go undetected so we mention these defects merely for the sake of the record.

As the baby is attended, the nurse observes his reaction to sudden noises or abrupt posture changes—both arms fly up and wildly thresh the air about him. The complete or partial failure of one or both arms to respond in this manner should be reported without delay to the attending physician. Such a report may lead him to suspect an obstetrical palsy or a fracture of the middle third of the clavicle. If the clavicle is fractured, the nurse may locate the callused area by feeling along the shaft of the bone. The brachial plexus passes under the mid-third of the clavicle and a fracture there traumatizes the plexus sufficiently to paralyze the muscles innervated at that point. An obstetrical or brachial palsy may be one of three types. The baby may not be able to move his arm away from his body—in abduction and outward rotation—and he may not be able to flex his elbow or supinate his forearm but all other movements are intact. This type is called Erb's or the upper arm type. The nurse may find that the shoulder movements are essentially good but that the movements from the elbow down are weak or completely paralyzed. This type is known as Klumke's or the lower arm type. Inequality of pupils, previously referred to, usually accompanies this type. Sometimes the entire arm is partially or completely paralyzed. This third type is called the whole arm type and is naturally of more serious import. The nurse should be prepared to give the physician an intelligent accurate report of the baby's limitations particularly if, as in some rural areas, the infant cannot be seen immediately by a busy family doctor. Frequently, on the basis of the nurse's report, the physician will suggest temporary supportive measures to prevent secondary disabilities from postural contractures. For example, he may order the baby's arm maintained in abduction by means of sandbags or a towel sling pinned to the bed. In the experience of the writer, sandbags or a towel sling are much more efficient than the so-called clove hitch bandage which encircles the baby's wrist and is tied to the head of the bed.

OBVIOUS DEFECTS such as complete or partial absence of bones and congenital segmental amputations will hardly be overlooked by the attending nurse or family. An occasional parent, however, may be most reluctant to have such disabilities brought to attention. In addition to directing her efforts toward preventing secondary contractures in adjacent normal segments, the nurse has the responsibility of helping the parents strive toward healthy emotional hygiene. In most instances the nurse herself will want guidance from a psychiatric social worker or a consultant in mental health. The nurse should be most cautious about discussing the immediate value of plastic surgery. She may find herself being trapped by her own emotions into telling the parents that something remedial can be done at once. Many mothers have gone to orthopedic out-patient departments, with hopes high, only to be told to return in a year or more. In great dejection, they say: "The visiting nurse told me something might be done—a bone grafted—I am so terribly disappointed."

Extra digits are sometimes present. If the additional one is a little finger or one of the central fingers, it is usually atypical and surgeons experience no difficulty in determining which should be amputated. If an extra thumb is present, however, skilled judgment and x-rays are required to distinguish the true thumb from the parasitic one.

Although the baby normally maintains his fingers in flexion, the nurse should have no trouble in passively extending all fingers. Occasionally, one or more fingers may be contracted in flexion. As a rule, these contractures respond well to corrective splinting, supervised or actual, applied by the attending physician. If the physician turns over to the nurse the responsibility for removing and reapplying the tiny splints at stated intervals, she must be most conscientious about following his instructions to the letter. Under no circumstances should the procedure be omitted, or curtailed, as the baby's fingers may very quickly contract in extension. (The physician always wishes to examine any joint which, in the opinion of the nurse, exhibits a persistent degree of flexion or rigidity. This should be kept in mind as joints are bathed.) Club hands and web fingers are other possible deformities of the upper extremity.

The rib cage may present a "rosary"—the index of rickets. At this time, the nurse might look for anterior and lateral bowing of all the long bones. Although rickets is essentially a public health problem, nurses in this field are not recognizing this condition early enough to make conservative treatment the treatment of choice. Too many children, with advanced bony changes, are being seen daily in orthopedic clinics for the public health nurse to complacently infer that this problem is under control.

AS THE NURSE bathes the lower extremities, she notes their activity. Are the normal kicking motions—alternate flexion and extension—vigorous? Perhaps one leg lies in pronounced outward rotation. Investigating further, the nurse finds that abnormal mobility is present on this same side, and she may have reason to believe that the leg in question is shorter than the other. She notes, too, that the inguinal folds are different, that the gluteal folds are asymmetrical, and that the pelvis on the suspicious side seems broader and definitely more flat than its fellow on the opposite side. All these symptoms, she tabulates mentally, and later, in her office, telephones the doctor, giving him an accurate report of her observations. The nurse knows the physician will investigate the possibility of a unilateral hip dislocation. If that diagnosis is established, and orthopedic treatment instituted, the nurse has the satisfaction of knowing that in all probability the baby will begin to walk without ever realizing nature intended him to walk with a waddling gait. If both hips are dislocated, habitual pronounced outward rotation of both legs is symptomatic.

As previously stated, a baby's knees tend toward flexion. Sometimes the knee joint is hyperextended, a genu recurvatum. Dr. Steindler[19] states: "Congenital genu recurvatum is one of the most difficult congenital deformities to treat. In the first place, really satisfactory results are obtained only by conservative treatment, and this implies that the treatment be instituted in the first few weeks of life." Certainly, from this statement, no doubt exists regarding the urgency of prompt identification.

The feet are next, and here the nurse, keeping in mind normal foot posture, notes any rigidity or limitation of motion. (In the first few days of life, a moderately sustained clonus

to the count of three to five is normal.[6]) A baby's foot may be moved freely in six directions:

1. Dorsi-flexion—straight up toward the shin bone. (Constant maintenance of this position is a calcaneus deformity.)
2. Dorsi-flexion and inversion—an "up and in" movement. (Deformity—talipes calcaneo-varus)
3. Dorsi-flexion and eversion—an "up and out" movement. (Deformity—talipes calcaneo-valgus)
4. Plantar-flexion and inversion—a "down and in" movement. (Deformity—talipes equino-varus)
5. Plantar-flexion and eversion—a "down and out" movement. (Deformity—talipes equino-valgus)
6. Plantar-flexion—a straight down movement. (Deformity—talipes equino)

If a baby's foot or feet are maintained habitually in any one of the six directions indicated above, a report should be sent to the physician immediately. The most common deviation from normal is a position of plantar-flexion and inversion—"down and in"—or talipes equino-varus. Early institution of treatment is of paramount importance in any type of clubfoot. The consensus is that every week of delay adds one month to the correction of the deformity.[7]

Other abnormal foot conditions which should be reported for medical examination are: Extra toes (polydactyly), congenital flat foot, forefoot adduction, hallux varus—the big toe swings in toward the midline of the body—the opposite of hallux valgus (or bunion), congenital clawfoot (pes cavus) where the longitudinal arch is contracted, and congenital gigantism of the foot where hypertrophy of the soft tissues as well as the skeleton occurs.

The nurse may find an overlapping little toe, and the doctor may suggest that she teach the mother to manipulate frequently the errant digit back in place. Occasionally, he may apply adhesive tape. If the condition persists into adult life, discomfort in footwear may occur. Webbing of the toes is often seen, especially partial webbing of the central toes. The physician may dismiss partial webbing as of scant moment but parents are apt to be concerned unless, as frequently happens, it is a family characteristic.

When the baby is turned over to be bathed posteriorly, any rotation of the spine or any defect such as a slight spina bifida or meningocele may be identified. In addition, the size and height of the scapulae should be noted. If one scapula is smaller and its inferior angle higher than the other, the physician will wish to consider the possibility of a Sprengel's Deformity. A short neck or other abnormalities in the cervical spine may accompany a Sprengel's.

Cerebral palsy is present at birth so the nurse should familiarize herself with suggestive signs and symptoms, such as: impairment of the sucking reflex, persistent hiccoughs, convulsions, jaundice, vomiting, abnormal tenseness at loud noises, and rigidity.[12] Any tendency of the baby to lie in an arched position with his weight resting chiefly on his head and heels is naturally so alarming that immediate medical attention is demanded.

A few precautions are suggested for the nurse who thinks she may have discovered a baby with a congenital defect. First of all, avoid obvious inspection and unnecessary alarm in your conversation or your actions in the hospital, home, or clinic. Remember the mother may be tired, worried, harassed, and easily disturbed emotionally. Discuss the symptoms accurately and conservatively with the attending physician; the responsibility is his to inform the parents that their baby has a handicap. If a doctor is not in attendance, work hard toward medical referral. If the parents resist medical referral, keep in mind that unless the reason for the resistance is known, the resistance cannot be overcome.[1] Sit down—let the parents talk—be a good listener. Avoid pressure, haste, and obvious lack of understanding and sympathy.

Diagnosis and suggestions for treatment are medical prerogatives and always confuse the family as well as the doctor if taken over by the nurse.

Remember after treatment has been initiated that failure to continue treatment is the great pitfall of orthopedics. Until physical restoration is a completed process, keep in touch with the family unless a medical social worker is actively interested.

SUMMARY

Nurses in the hospital and in the home have many and varied opportunities for identifying

the infant who is born with a congenital orthopedic handicap. An awareness of the varying stages of normal motor development and of signs and symptoms indicating specific congenital disabilities should be part of the basic knowledge of all nurses. Medical referral is the first objective, followed by sustained interest and care until rehabilitation is complete.

A reprint of this article will be available within a month from the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, New York. Write for free copies.

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Work of the NOPHN Must Go On!

(Continued from page 580)

2. What is the number and the type of personnel needed and what revisions of existing standards are needed? This should determine the balance between public health nurses, professional nurses with no special public health preparation, practical nurses, and non-nurse personnel, and the duties for which each should be used.

3. What should be the visit schedules, the content and timing to obtain most productive results?

4. What are the relative values of different methods such as individual instruction, group instruction, letter or telephone to secure objective? For what services and under what circumstances are the varying channels of communication useful?

5. What are the costs involved?

The answers to these questions are within the scope of the obligations of this agency. The answers would be of inestimable value in the stimulation and professional guidance which is so earnestly wanted by official and voluntary agencies alike. I know the Committee on Nursing Administration is giving serious thought to ways and means to get these studies under way.

There are serious tasks ahead. The rapid social changes are breath-taking. We must not fail to keep pace with them for want of energy and courage to express our collected decisions regarding the place nursing should take in this nation and in the world.

Of The Biennial—and Things to Come

THE SUN rose on Monday morning at Atlantic City and its cheerful brightness greeted the first day conventioners. This was the first visit to the playground of the eastern coast, a first view of the Atlantic Ocean, for many of the delegates and members attending the first postwar Biennial Nursing Convention of NOPHN, ANA, and NLNE, and, on the whole, Atlantic City put on a good show. Not that there was much free time for enjoying the smooth, clean beach or the everchanging panorama of the ocean, but it was nice to know they were there, and every once in a while one passed a window in Convention Hall and stopped to enjoy the majestic scene without.

But, of course, what is really important at a convention are the people. Representatives from every state of the Union, from the District of Columbia, Alaska, Hawaii, Puerto Rico, Canada, from the Philippine Islands, and many Central and South American countries were registered on the first day. Before the curtain went down on Friday, 6475 nurses had registered.

The general arrangements were in charge of NOPHN, it being its turn in the rotation of turns for nursing biennials. The joint program committee of the three national nursing organizations had done a magnificent job of arranging joint programs, general and special interest programs. With the exception of one special meeting called on Friday no programs were scheduled during the time the House of Delegates was in session. For the first time because of this fine planning it was possible for all interested members other than the delegates to attend all of the House of Delegates meetings.

The House of Delegates. From the time we are student nurses probably studying "professional adjustment" we hear about this body, and how little most of us know about it. In the corridors of Convention Hall, on the boardwalk, in coffee shops, in hotel lobbies, at listening posts all over one heard, "I am going to the House of Delegates. I have never been before." "Come, let us go to the House of Delegates. We should know what is happening." "Aren't you going to the House of Delegates?"

There was a vibrant feeling throughout the convention that important events would occur in the 1946 meetings. They lived up to what was anticipated of them. The delegates deliberated, reported, argued, and decided. Many of the decisions you have already read about and many you will continue to hear of. The actions of the house were important. But what will live in the memories and hearts of many present at the deliberations is the spirit that was shown throughout. If there ever was any doubt about it, nursing has come of age! Subjects of tremendous import to individuals, to groups, to states, to the nursing profession, were approached and discussed with sincerity, and on the whole with an impersonal concern for the greatest good to the greatest number. A visiting speaker was heard to say, "I never heard any better debate in Congress." A realization of deep-seated individual and group responsibility was reflected in all the deliberations, and whether or not one agreed wholeheartedly with all decisions one was warmed with the glow that permeated the large meeting hall.

The meeting rooms at the Atlantic City Convention Hall seemed commodious, and yet there were many sessions at which an SRO sign could well have been hung out. The ball room was set up with seats for about 3,000. When the room was almost filled with an alert and attentive audience one could not help but be aware of the allegorical significance of the ceiling decorations—the solar system in all its glory, with rays of sun traveling off into space.

The theme of the convention was "Nursing in the Nation's Plan for Health." Each one came away with her own version of the highlights of the week. This reporter was impressed with the interest of the non-nurse members and visitors and speakers in the future of nursing; their sincere respect for nurses and nursing, and their equally sincere desire to know more about us and to share their knowledge with us generously; the emphasis

on certain subjects, such as counseling and personnel policies, mental hygiene, care of the chronically ill, and rehabilitation. Meetings were given over to the discussions of these topics. But what was of greater interest was the frequency with which these topics crept into other discussions, which demonstrated how vital is the profession's concern with these problems and how clear is their appreciation of what someone called "cross-fertilization of ideas."

Another topic that kept coming to the fore was that of the nurse's role in public relations. Nursing belongs in the world—in the world of daily events—and the nurse of today and tomorrow must take her place as a vocal, responsible citizen and not be content to remain within the narrow environs of an isolated activity. Nursing has never been an isolated activity but some of her practitioners have tried to escape the significance of this in their adherence to tradition. The nurse must be active in public affairs and if public relations carry a negative connotation for some, remember at best it means "conditioning and stimulating thinking along certain lines." The responsibility of nursing today is to stimulate thinking along those paths which lead to better community nursing service and in the end good health for all the people.

One of the speakers referred to "the gateway of peace." Public health nursing has definitely chosen to pass through the gateway of peace marked "Community Organization." The program of the first NOPHN general session was entitled, "Organizing the Community for Public Health Nursing." The second general session was given over to "Defining Public Health Nursing." On this program a panel of professional and other citizens enacted "A Community Meeting." On Wednesday a joint session program centered around "Community Planning for Nursing Service and Nursing Education." The attendance at all these meetings far outnumbered what was expected. The speakers were some of our outstanding nursing leaders, our friends of other professions, and other interested and informed citizens. Innumerable requests for copies of all these papers again demonstrates the active interest in the problems facing our profession if we are to fulfill the functions that modern society expects of us. (Most of these papers will be printed in early issues of PUBLIC HEALTH NURSING and the *American Journal of Nursing*.)

The Structure Study report made its formal debut, under the auspices of Mr. Raymond Rich. Like many other works of art—and it is a work of art—it had been anticipated throughout the land with various emotional reactions and much conjecture. In view of the fact that this report, regardless of final decisions, will affect nurses and nursing for years to come, the importance given to its several appearances at the convention was not exaggerated. Organizations concerned voted to go ahead with an enlarged Structure Study Committee which is charged with further study of the report and the collection, analysis, and interpretation of nationwide nursing opinion in regard to its provisions.

There were some more joyous moments at the convention, also. The ANA celebrated its Fiftieth Anniversary at the joint session on Tuesday evening and Helen Jepson sang. The NOPHN had a membership rally supper preceding the joint session. At the rally Miss Mary S. Gardner, honorary president of the NOPHN, was the star. Her spirit and inspiration shine on and her devotion to public health nursing and all those who follow the path warms us with its encompassing glow. A quartet serenaded Miss Gardner, and later all joined in song. It did not sound like Helen Jepson, but it was fun.

And have you heard about the national uniform for public health nurses? It comprises several costumes suitable according to the occasion and season: a basic navy wash dress, a seersucker dress and jacket, a wool suit and blouse and a winter coat and hat. Are 25,000 women going to rise in agreement and approve every line, every tuck, every gusset? No, of course not, but at the NOPHN closing business meeting the membership present voted to recommend a standard uniform for all public health nurses in all agencies and the uniform shown at the convention as that standard. Each agency is to select that part of the uniform which best fits the needs of the agency and the climate. Three cheers for our American designers and tailors, and for our Uniform Committee, too!

The convention began to break up on Friday. Faces and voices that had become familiar during the week were beginning to be missing. It had been a strenuous convention

but a revitalizing one. Surely the 1946 Biennial Nursing Convention has offered a fertile field for the germination of ideas. Nursing in the nation's plan for health—the vistas before us—nurses, citizens, all—are breathtaking.

H.C.

Planning Together for Field Service

THE first meeting of regional field consultants of the federal and national agencies to consider their mutual interests and problems was held September 22, just prior to the Biennial Convention in Atlantic City. There were present 57 public health nurses, representing 7 different agencies. The meeting was so helpful that it was voted to form a permanent committee of field consultants as a subcommittee of the Committee on Nursing Administration of the NOPHN.

The program for the Sunday conference was centered on a discussion of the statement, "Desirable Organization of Public Health Nursing for Family Service."* Alma Haupt, who as chairman of the NOPHN Postwar Planning Committee had urged the development of a statement on organization and administration of public health nursing services which would represent all agencies, opened the discussion by giving a review and forecast. She said, in part:

We may consider the statement, "Desirable Organization of Public Health Nursing for Family Service," as a platform for a united front.

It is a platform for bringing together our philosophies, for guiding us in our social engineering. And, we hope, it will be a springboard for vigorous and successful action.

For upon the best possible local organization of public health nursing depends our ability to serve the individual and the family and through them the community. Proper distribution of public health nursing service, broadened programs, increased support, increased numbers of well prepared nurses, all are dependent on sound local administrative organization.

You may well say there is little that is new in this statement. Much of its content has been said over and over again. However, I believe it is new in three very important respects.

First, it attempts to give an over-all view of local public health nursing organization, putting together many facets formerly discussed separately.

Second, it attempts to represent and weld the philosophies of public and private agencies, and the broad aspects of public health nursing relating to health education, disease prevention, and care of the sick.

Third, it is the first time in the history of public health nursing, in this country, that the major federal and national agencies concerned have jointly prepared and sponsored a statement of this kind.

Historically also, I believe, this is the first time that the regional field consultants of the federal and national agencies have all come together for consideration of their mutual interests and for blending their various skills and points of view. What a tremendous force you are and what an opportunity each one of you has to present this united front to all parts of our country!

Frankly, this document is an experiment to see if we can all agree. Let us try to serve the individual, whether in sickness or in health, by one and the same nurse and see what happens. Is the family doctor satisfied, are the individual and family satisfied, is the responsible organization satisfied in relation to all of its teaching and clinic services? The system has worked in many communities. Does it now meet the needs of expanding public health, hospital, and medical care programs? We must watch developments carefully and, if legitimate dissatisfactions arise, decide to try something else. At least we can say that we have gone all out for unification, that it did or did not work, and know the reasons why.

The place of the public and private agency must also be kept in mind. In a democracy, the citizen participates through both. With increased public support especially through federal and state funds, we must continue to keep a balance between the public and private agencies. Let us keep in mind the Gunn-Platt Report and the vital contribution which private agencies make to public health nursing. A way must be found to maintain citizen interest and participation as exemplified by active membership on boards and committees and through volunteer service. Through the voluntary agencies there is invaluable relationship with local community chests and councils which should be maintained no matter what the form of local organization for public health nursing. But the voluntary agency picture is confused with too many agencies in some communities and none in others.

And so, I understand, this group has met together to review this platform in the light of your own varied field experience, to learn from each other and to plan ways and means for putting this platform into action. It is now brought to you for your suggestions as to how it can be applied in the field.

The group voted unanimous acceptance of the statement, "Desirable Organization of Public Health Nursing for Family Service," and expressed their belief in its practical application. In order to accomplish this, it was agreed to seek opportunities to put the principles expressed into practice through field visits, inter-agency conferences, and mutual planning of consultants.

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*PUBLIC HEALTH NURSING, August 1946, p. 387.

Public Information Tips

To make this column as helpful as possible, we need information about what your agency and your community are doing to further interpretation of public health nursing service. Won't you please send samples of newspaper items, radio scripts, leaflets, booklets, annual reports, posters, speeches, and anything else you have prepared? Mention in this column is a means of getting a wider audience for your material. E.W.

A PUBLIC INFORMATION COMMITTEE is now being organized to help guide NOPHN in its public information policies, give advice about publications intended for the public, and steer Public Health Nursing Week April 20-26, 1947. Chairman of the Committee is Mrs. Philip A. Salmon, member of the Executive Committee of the NOPHN Board and Committee Members Section and president of the Visiting Nurse Association of the Oranges, New Jersey. Members of the Committee will include board and committee members of NOPHN member agencies, public health nurses, and public information experts.

. . . . .

Under preparation is the publicity kit and publicity aids for Public Health Nursing Week. It is hoped they will be ready for distribution by December 15. Among the aids being planned are a poster, comic book for school children, trailer for motion picture theaters, two fifteen-minute dramatic transcriptions for radio, a "throw away" interpreting public health nursing service. Through special funds NOPHN is underwriting the major part of the cost of producing all publicity aids, but these funds are not ample enough to permit free distribution. Communities will be asked to pay a nominal charge for everything. Definite announcement about the kit and the aids will appear in the winter issue of *Phn*, the quarterly bulletin which is sent to all NOPHN individual and agency members.

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An attractive window display carrying out an excellent idea was arranged by the Department of Educational Nursing of the Community Service Society of New York City in cooperation with the Bank for Savings during the month of August. Theme of the display was "Community Service Society Points the Way to Balanced Living"—a good tie-in with the bank and bank balances. Here is a description of the display written by Lola Laffay of the Lenox Hill Nursing Service of the Society: "On August 2, in a window of the Bank for Savings, there appeared an almost life-sized portrait of a family seated at the table. The aura of happiness and well-being emanating from this family group gives silent testimony to the fact that they have found 'balance.' The model of a nurse which stands beside the picture (pointing toward the picture) was intentionally made small in size to indicate it is her role to point the way for the family, to guide and to help them, but never to imperil their own integrity. She is an integral part of the tableau, just as she is of the community in which she works, and evidence of her achievement can be read in the happy, healthy faces of the family members. Inside the bank, in three large showcases, the theme of balanced living is emphasized in displays arranged by the nurses and nutritionists. Here again interest is centered on the family, with only an implication that the nurse and nutritionist stand ready to serve. . . . To provide something tangible for visitors to carry away with them, and to remind them of what they have seen, leaflets were available for all who wished to take them." Staff members designed and worked on the project, but they found this very time-consuming. They recommend that any other groups planning a similar display (1) consider carefully whether it is not really more economical to have the work done by a display company (2) have early agreement about a theme and the complete cooperation of every staff member (3) analyze all details in the display to make sure they really carry out the theme. (This last recommendation is especially important in order to make sure the display aims at one single dramatic effect and does not dissipate its message among extraneous details.)

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A new publication on radio, prepared by the National Publicity Council, will soon be added to the "how-to-do-it" bulletins which NOPHN is making available as a service to individual and agency members. This bulletin is packed with background information about radio which everyone should have, helpful do's and don't's, and samples of good radio writing. The bulletins will be sold at a special discount to NOPHN members, but no quotation can be made now because printing costs have not yet been determined. Watch this column for announcement about when the bulletin will be ready for distribution.

Reviews and Book Notes

PRINCIPLES OF PSYCHOLOGY FOR THE BASIC COURSE IN NURSING

By Rev. J. Edward Rauth, O.S.B., Ph.D., and Sister M. Maurice Sheehy, R.S.M., Ph.D. 200p. The Bruce Publishing Company, Milwaukee, Wisconsin. 1945. $2.00.

Anyone who desires to gain an understanding of what psychology is and how it can be utilized by the nurse would do well to read this book. It is readable, with many interesting and pertinent examples. The anatomical background and the terminology necessary for understanding the psychological content is presented briefly and clearly, with effective illustrations.

The book does not seem desirable as a text. It does not supply the facts and materials with which a text usually supplements classroom discussion. The importance of mental hygiene and community health programs are not included in sufficient detail considering the amount of psychological application which is, in these times, expended upon them. The chapter on statistics is essential for the graduate nurse but is advanced for the student nurse. An excellent part of the book is that which considers study habits and plans and also that which considers a "Plan of Life."

On the whole, while this book does not seem useful as a text, it is excellent as a basic course or review for the older nurse who wishes to broaden her concept of human behavior so that she can better understand normal and psychotic personalities.

—EMILY ADAMS TAIT, *Assistant Director, Jewish Hospital of Brooklyn, Brooklyn, N. Y.*

HEALTH CARE OF THE FAMILY

By Ramona L. Todd, Ph.D., M.D., and Ruth B. Freeman, M.A. 530 pp. W. B. Saunders Company, Philadelphia. 1946. $3.00.

Written for college students and others interested in family health conservation, the author begins with informative chapters on environment and prevention of disease, going on to reproduction, individual health care, and home care of illness. It is disappointing to find this stereotyped presentation of family health conservation. In the light of our present knowledge and understanding of the factors involved in the development of effective family living, one would look for more interpretation of relationships.

Emotional aspects of health are tucked in throughout the book, but are not sufficiently emphasized as, for example, in the sections on breast feeding and important principles of infant care. The chapter on aspects of childhood behavior offers many helpful suggestions, but here again attention is centered on the technics of child care and training rather than on the relationships involved in living together healthfully in a family. In the part entitled Home Care of Illness, suggestions for the care of the sick patient are outlined in a helpful manner.

—EVELYN A. ELLINGSON, R.N., *Regional Nursing Consultant, Bureau of Public Health Nursing, Michigan Department of Health, Lansing, Mich.*

FOLKS DO GET BORN

By Marie Campbell. 245 p. Rinehart and Company, New York, N. Y. 1946. $3.00.

This truly delightful book is the story of Negro granny-midwives who take care of the birthing of babies, both black and white, in so many rural sections of Georgia.

The granny-midwives told the author, "we think that you better put first the part that tells about the granny-midwives being on the Board, about their connections with the nurses, about their midwife clubs and their other kinds of meetings, and all kinds of true facts about the grannies. Then when folks read the part of your book where the granny-midwives talk sociable in a kind of story fashion, then folks will have in the back of their heads the part that is in the manner

of explaining, and they will know and understand all of what the grannies are talking about and not be ignorant."

The grannies were certainly right This background material about the ancient hereditary practice of midwifery makes their "talking sociable" even more appealing. Here are stories of every sort, touching, heartwarming, amusing, and pleasantly ghostly. The author shows a true touch in transcribing the vernacular of the rural Georgia Negro.

Much of the material was gathered by the writer from many visits where she "talked sociable" with the midwives and according to her acknowledgements, the book could not have been written without the help of the public health nurses who train and supervise the grannies.

—Mrs. Bessie F. Swan, *Associate Director, Department of Public Health, Atlanta, Georgia.*

GUIDE FOR PARENTS OF A PRESCHOOL BLIND CHILD

By Gertrude Van den Broek. 48 p. Commission for the Blind, New York State Department of Social Welfare, New York, N.Y. 1945.

This pamphlet is based on seven years of sympathetic study and training of numerous preschool blind children in the home environment.

It deals with the preschool blind child's situation, his physical, emotional, mental, social and spiritual development and needs as well as what may be expected of him. It is written in a clear, concise, non-technical manner expressly as a guide for parents of children born blind or with impaired vision.

The writer advises parents to develop and maintain a healthy attitude toward the child's handicap by accepting his condition as a challenge rather than a burden. A blind child is affected far more than a normal child by the quality of the parents' devotion. However, care must be taken to treat him as nearly as possible as if he were a "seeing" child to enable him to adjust himself to accept the demands of life. Often parents are likely to be confused about the child's misfortune and feel unable to cope with the problem. Consequently, there is a tendency to want to place such a child in an institution, but the writer stresses the need for him to remain at home until he is of school age.

Many helpful and practical suggestions relative to special equipment and methods for guiding such children are clearly defined. The last section lists standards of achievement for blind children with normal mentality as well as suggestions for training them on a yearly basis. This guide will be particularly helpful as a means of checking the child's progress and reassuring the parents as to his development. An excellent bibliography is included.

Although this pamphlet was written for parents, it may well be read and studied by public health nurses, in fact, by all who work or are associated with preschool blind children.

—Alberta B. Wilson, R.N., *School Nursing Consultant, National Organization for Public Health Nursing, New York, N. Y.*

REHABILITATION, RE-EDUCATION AND REMEDIAL EXERCISES

By Olive F. Guthrie Smith. 424 p. The Williams & Wilkins Company, Baltimore, Maryland. 1943. $6.00.

Mrs. Smith states that "the object of this book is (1) to show the scope of work that a physiotherapist is called upon to undertake in general and special departments, (2) to try and fill some of the gaps in physiotherapy."

In the introductory section the author stresses that treatment is based on three principles—psychological, physiological, and mechanical. The first step and an absolutely essential one is to awaken in the patient a will to recover. This will to recover and the cooperation which goes with it are essential if a program of muscle re-education is to be successful.

The book stresses the value of active exercise. Mrs. Smith states that from this type of exercise one obtains more rapid and lasting remedial effects. Many types of apparatus are discussed and illustrated but she warns the therapist against using apparatus in such a way that the exercises degenerate into mechanical actions. Patience, intelligence, and originality are necessary qualities for a physical therapist giving muscle re-education. Exercises are discussed in general as to technics and objectives and later taken up with respect to specific types of conditions.

Believing that the emphasis must always be on self-activated movement, the author

devotes the first part of the book to early rehabilitation. She then discusses work and games as a form of re-education and ends with several chapters on passive treatment such as Electricity in the Service of Rehabilitation, the Value of Massage in Skin Graft and a chapter on Massage and Rehabilitation.

This book is one which would be of most value to the therapist working in a treatment center where apparatus is available. The home therapist could profit by her general principles and some of the exercises but rarely does one find, in the home, the type of apparatus listed here.

—HELEN M. LEHMANN, *Consultant, Detroit Visiting Nurse Association, Detroit, Michigan.*

A MANUAL OF TUBERCULOSIS

By E. Ashworth Underwood, M.D. 524p. The Williams and Wilkins Company, Baltimore, third edition, 1945. $4.50.

For nurses who are eager to find, in writing, a description of tuberculosis which will help them to understand the disease more thoroughly, this is an excellent book. Dr. Underwood meets a long felt need because his book explains and describes vividly, in logical sequence, how tuberculosis develops and progresses in the human body.

Several chapters are devoted to discussion of the surgical and medical treatment of tuberculosis. In addition, there is an important chapter which calls attention to the need for recognizing and treating the mental aspects of the tuberculous patient.

In the last few chapters, the author discusses succinctly the effects of the disease on the community and how all community resources are necessary to transform a disabled person into a functionally sound member of society.

An excellent glossary and chapters well summarized are other features which make this book useful.

—RUTH C. FARMER, *Consultant, Tuberculosis Nursing, Department of Health, Detroit, Michigan.*

RECENT PUBLICATIONS AND CURRENT PERIODICALS

NUTRITION

TABLES OF FOOD COMPOSITION IN TERMS OF ELEVEN NUTRIENTS. Prepared by Bureau of Human Nutrition and Home Economics, U. S. Department of Agriculture in cooperation with National Research Council. Miscellaneous Publication No. 572. 1945. 30 pp. U. S. Government Printing Office, Washington, D.C.

GENERAL

THE GREEN LIGHT. May 1946, 15 pp. National Association to Control Epilepsy, Inc., 22 East 67th St., New York 21, N. Y.

HEALTH AND EMPLOYMENT. By Myra E. Shimberg, Ph.D. For the North Atlantic District of the American Association of Medical Social Workers and the Department of Welfare, New York, N. Y. 1946. 128 pp. National Council on Rehabilitation, 1790 Broadway, New York 19, N. Y. $2.50.

It is a study of public assistance clients attending out-patient department clinics.

RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE. By Mary H. Easby, M.D. *The Family*, January 1946, page 340. Family Welfare Association of America, 122 E. 22nd St., New York 10, N. Y. Single copy: 25c.

CORRECTIONS: In the September PUBLIC HEALTH NURSING, the footnote (p. 465), to "School Health Institutes in California" by Rena Haig, R.N., stated through error, that Dr. L. C. Newton Wayland's article on the "Protection of the Health of the School Staff" would appear in the October issue. That particular article is to appear in the *Journal of the National Education Association* early in 1947. The article by Dr. Wayland appearing in the October Magazine is entitled "School Nurse, School Physician and Teacher Health."

In September this appeared in "The Health Institute of the UAW-CIO," page 467: "Should the patient have no family physician, he may elect to go to any member of a panel of properly qualified practitioners which is furnished him by the Health Institute upon the advice of the county medical society." The authors wish us to make the following correction relative to this statement: The Wayne County Medical Society does not furnish restricted panels of this character, and the panel described was selected by the administration of the Health Institute.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

STANDARD UNIFORM RECOMMENDED FOR PUBLIC HEALTH NURSES

NOPHN members attending the NOPHN business session at the Biennial Nursing Convention, September 27, voted to recommend that all public health nursing agencies, according to their needs, adopt the standard uniform that was shown at the Convention by the National Uniform and Symbol Committee. The complete uniform outfit, modelled at the September 23 business session and again at the membership rally September 25, consisted of a navy blue whipcord topcoat with removable red flannel lining and removable collar; navy blue wool suit (for public health nurses not giving bedside care); navy blue washable dress with long or short sleeves for nurses giving bedside care; blue and white striped seersucker summer dress with matching jacket and skirt (if a three-piece summer outfit is desired); a navy blue felt hat adjustable to suit all sizes, ages and shapes, and a white apron with an adjustable waist line. An overseas cap in navy blue whipcord to match the topcoat and in seersucker for summer will also be provided for those nurses who prefer that type of hat.

The uniform outfit, designed by Mme. Edith d'Errecalde, prominent designer of New York City, was the result of suggestions received from staffs of more than 200 public health nursing agencies in all parts of the country who responded to a questionnaire sent out by the National Committee. As these suggestions were almost unanimously in favor of navy blue, a collarless dress that would be easy to launder, a suit for those public health nurses not giving bedside care, a hat becoming to many types of faces and a topcoat that could be worn in spring and fall as well as in winter, Mme. d'Errecalde did her best to carry out these ideas. In doing so she made the dress collarless with a neckline that could be worn high or low and with a removable white bow to relieve the starkness of all blue; the topcoat with a removable lining and collar; and a brimmed felt hat that can be worn in six different ways. Manufacturers who cooperated in the making of the sample outfit shown at the Convention were Altro Work Shops, Bruck's Nurse Outfitting Co., New York City; Hopkins Tailoring Company, Baltimore, Maryland; and McHenry's, Cleveland, Ohio; Dobbs Hats, N. Y. C.

Because of the critical shortage of materials and because of the fact that minor changes on the sample uniform are needed, there will be a delay of several months before the complete outfit will be ready to be produced in any quantity. Exceptions are the suit and topcoat which are now in production.

Orders for the uniform should not be sent to NOPHN but directly to the manufacturers listed above.

NURSING OBSERVATION IN INFANTS AND CHILDREN

The Joint Orthopedic Nursing Advisory Service now has ready for distribution a set of 62 2x2 inch film slides, including Kodachrome and black and white, accompanied by a detailed script, to be used by nurse instructors in teaching the inspection of the newborn and infant. Of these slides 30 show the premature and mature infant, demonstrating normal growth and development; 32 slides, common orthopedic deviations. The student must be thoroughly familiar with the normal infant, his growth and development, in order to intelligently observe and detect deviation. These slides were prepared under the supervision of Miss Mary Macdonald whose article "Nursing Observation of the Infant" appears on page 615.

Slides and script are available to both public health and nursing school instructors on a loan basis, the only charge being for return shipment by Railway Express Agency.

Although JONAS has a number of sets of slides it would be well to send requests at least a month in advance of the date of showing, because of shipping difficulties and increasing demand for visual aids.

NFIP SCHOLARSHIP GRANT

The orthopedic scholarships made possible by a grant from the National Foundation for Infantile Paralysis and until July 1, 1946 administered by the National League of Nursing Education and the National Organization for Public Health Nursing are now being administered directly by the Foundation. The centralization of administration of all the scholarship grants of the NFIP is expected to make possible

a more effective public information service concerning the broad scope of the Foundation's educational grants. The NLNE and NOPHN will continue to give information about desirable preparation and counseling service to applicants and the Joint Committee on Orthopedic Scholarships will continue to select candidates for the awards and to develop policies concerning prerequisites, type of preparation, and subsequent experience needed to prepare the nurse for this special field. The credential secretary of the Foundation will receive application blanks (both directly and those forwarded by JONAS), collect transcripts of credits, and organize and type summaries to be presented to the Scholarship Committee.

LOST AND FOUND AT THE BIENNIAL

The following articles, turned in at the Information Desk during the 1946 Biennial Convention at Atlantic City, may be claimed by writing Wilkie Hughes, Executive Secretary, Room 1112, 17 Academy Street, Newark 2, New Jersey: *Fountain pens*—black Schaefer with name "Mercedes R. Immel"; green and black Schaefer; black with gold "Wear Ever." *Glasses* —lorgnette—gold rimmed with black ribbon; pair with light frames with name on case of "J. S. Wilson & Sons, 865 South Broad Street, Trenton, New Jersey"; green sun glass case—empty. *Gloves*—2 pairs of black kid; pair of brown pigskin; pair of brown fabric; pair of black fabric; 1 each black suede, neutral suede, white fabric. *Jewelry*—silver earring; gold class ring engraved "J. H. '45," caduceus with mother-of-pearl with initials inside "MMH." *Rosaries* —black crucifix (4-inch) with part of rosary; black rosary (18-inch). *Miscellaneous*—white scarf; sugar stamp (Dorothy Thompson); small bottle medication from New Weston Pharmacy, New York City.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
APHA Convention	Cleveland, Ohio—Nov. 11-14
Ruth Houlton*	
Mary C. Connor*	
Hedwig Cohen*	
Ruth Fisher	
Louise M. Suchomel	
Alberta B. Wilson	
*also attending Collegiate Council and NOPHN Education Committee meetings, Nov. 9, 10, 11.	
Other Field Trips	
Mable Grover	Camden, N. J.—Nov. 6
	Roanoke, Va.—Nov. 25-27

New Topcoat for public health nurses.

Margaret Ladd	Minneapolis, Minn.—Oct. 7-Nov. 7
Sarah A. Moore	Englewood, N. J.—Nov. 11
Eleanor Palmquist	Birmingham, Ala.—Nov. 2
	Macon, Ga.—Nov. 3-5
	Tennessee—Nov. 6-16
Dorothy Rusby	California—November
Louise M. Suchomel	Kansas City, Mo.—Oct. 31-Nov. 1
	Toledo, Ohio—Nov. 17-19
Dorothy Wiesner	Orange, N. J.—Nov. 14

In October, field trips in addition to those already listed in the October issue of the magazine, included the following: Eleanor Palmquist—Oklahoma; Alberta B. Wilson—Leominster, Mass.; Louise Suchomel —Minneapolis, Minn., Wilkes Barre, Pa., and Omaha, Neb.; Agnes Fuller—Binghamton, N. Y.; Hazel Heringshaw—Boston, Mass.; and Dorothy Wiesner—Montclair, N. J.

NEW PUBLICATIONS

NOPHN announces the publication of two new booklets: "Personnel Policies for Public Health Nursing Agencies," intended as a source book in establishing personnel policies; and "Part-time Nursing in Industry," dealing with problems in this field. These publications are 75 cents each and will be forwarded to you from National Headquarters upon order.

NEWS AND VIEWS

On National Nursing

SOCIO-ECONOMIC STUDY OF NURSING PROFESSION

The Bureau of Labor Statistics and Women's Bureau of the U. S. Department of Labor in cooperation with the National Nursing Council begins this month a nationwide study of nurses and the nursing profession. Its purpose is to study the causes of the inadequate nurse supply in relation to the present public demand.

The study, as described by Mrs. Aryness Joy Wickens, assistant commissioner of labor statistics, at the Biennial Convention, comprises three parts: (1) a mail questionnaire to 40,000 representative nurses, designed primarily to indicate facts about nurses who have stayed in the profession (2) a personal interview with about 300 women who have left the nursing profession, intended to discover why they left and (3) comparison of the social and economic status of nurses with other groups in similar fields. The survey seeks to secure information about earnings, working conditions, training, experience, and other pertinent facts.

Usual questions such as those about total monthly earnings, allowances for room and board, marital status, et cetera, will be supplemented by questions as to:

Actual conditions of work;

Reasons for transferring to other work;

Reasons for returning to nursing after having tried other work;

Differential in salary between night and day duty, and rotation of the two;

Type and condition of living quarters provided;

Number of hours during which the nurse is "on call";

How far in advance the schedules of hours on duty and "on call" are posted.

To supplement the facts which the questionnaires will reveal, experienced bureau interviewers will talk personally with a small group in an effort to learn why nurses leave the profession for other fields. Names of persons with at least two years' experience in professional nursing who have left the field within the past two years and are now gainfully employed in some other occupation are being compiled in ten cities—San Francisco, Denver, Chicago, Dallas, Atlanta, Detroit, Cleveland, Philadelphia, New York, and Boston. Those actually interviewed will be selected to represent the various nursing specialties, such as obstetrics, surgical nursing, and also the different fields in which nurses serve, such as public health, institutional nursing, and private duty.

The cross-section of nurses reached by this poll will represent the whole profession. Each individual nurse whose name is picked to receive the questionnaire, needs to remember that in spite of its formidable look, forty-five minutes is all the time required to fill it out. Answering these carefully chosen questions, either on the questionnaire or during an interview, will help form the revealing picture necessary to solving the country's critical nursing shortage problem. All information given either in questionnaire or interview will be carefully guarded and held strictly confidential.

The results of the survey, sorted and tabulated, will present understandable summaries that on study will hold answers to many questions important not only to nurses as a whole but to each one individually. The results will be published for the use of everyone who is interested in the nursing profession.

HOSPITAL NURSES RECEIVE INCREASES

It is significant of the times that shortly after the publication of "Personnel Policies for Public Health Nursing Agencies" in which appears the statement "the working hours should conform to the standard of a 5-day and 40-hour week," that the Department of Hospitals, City of New York, reached a similar decision. The almost 3000 registered nurses employed in the city's Department of Hospitals began the 40-hour week on October first. It is most agreeable to see nursing in hospitals marching on with the times and it is hoped that more hospitals and public health nursing agencies also will be able to make these adjustments soon.

Three leaders of nursing attend the Biennial Convention: Ruth Sleeper, Katharine J. Densford, and Marion W. Sheahan, presidents, respectively, of the National League of Nursing Education, American Nurses' Association, and the National Organization for Public Health Nursing.

From Far and Near

● The 1946 conference of the National Society for the Prevention of Blindness, Inc., will be held November 25-27, 1946, at the Hotel Pennsylvania, New York City. Among the subjects to be studied will be "Medical Advances in Restoring and Conserving Vision," "The Vision Program in Industry," "Developmental Eye Conditions in Children," and "Meeting the Need for Professional Personnel in Sight Conservation—Nurses, Medical Social Workers, and Teachers."

● The New York Academy of Medicine announces its Lectures to the Laity for 1946-47, which will be grouped under the general subject of Medicine in the Postwar World. If further information is desired, write to 2 East 103 Street, New York City, where these addresses will be given. Admission is free.

● The Association for Advancement of Research on Multiple Sclerosis, an organization to combat this serious nervous disease, has been recently formed by patients, friends and relatives of patients in cooperation with neurologists. It is located in the Academy of Medicine Building, 2 East 103 Street, New York City.

● The National Society for the Prevention of Blindness announces the establishment of 9 one-year scholarships of $1,000 each for students interested in professional education to qualify for positions in the field of sight conservation and prevention of blindness. These positions, which require both community organization and case work skills, offer a variety of opportunities for staff workers, consultants, and executives. Positions are open in public and private prevention of blindness agencies, in hospitals, and in organizations offering medical care programs. The scholarships will be available beginning with the spring term, 1947. Application blanks may be secured by writing to the National Society for the Prevention of Blindness, 1790 Broadway, New York City 19.

● The National Society for Crippled Children and Adults, Inc., will hold its twenty-third Annual Meeting on December 9, 10 and 11, 1946, at the Palmer House, Chicago, Illinois. The convention theme will be "The Challenge of the Future." The program will include sessions on recreation, rehabilitation, convalescent care, and cerebral palsy.

● The National Industrial Conference Board reports that in 25 selected manufacturing industries women's average weekly earnings for May and June were, respectively, $32.96 and $33.40. Their average hourly earnings for May were 85.6 cents; for June 86.4 cents. Women averaged weekly hours for the same months, of 38.6 in May and 38.7 in June.

Food Packages for Europe—The Cooperative for American Remittances to Europe, Inc., can help you feed famine-ridden thousands. Established by 24 relief agencies and endorsed by the U. S. Government, CARE sells, ships, and delivers food packages direct to individuals or organizations across the Atlantic. These packages, containing 40,000 Calories of highest quality American food, can supplement for 50 days one European's meager rations. Each package can now be purchased by the sender at the reduced price of $10. For further information write to CARE, 50 Broad Street, New York 4, N. Y.

Housing Shortage—As the army of home seekers in the country continue to swell, large-scale plans are being formulated to meet the housing shortage crisis. The U. S. Government, through its various agencies, offers help to returning GI's and others needing homes by granting priorities on materials for veterans' homes, extending loans, restricting non-residential construction, and by taking various other steps to speed production. Local communities, tackling the problem through the Mayors' Emergency Housing Committees, determine local housing needs and how they can be met with the help of government aids. Support of or participation in one of the 580 of these committees offers the public health nurse the opportunity, as a public minded citizen, to help balance the supply and demand of U. S. housing. These Mayors' Emergency Housing Committees, and other women's organizations working with them, strive, among other things to see that sufficient lots with sewer, water and other facilities are available for housing projects and that building codes are brought up-to-date to permit use of appropriate new materials. Women's groups can also urge that good homes be built within the price range of lower incomes. They can insist on substantial construction to insure good homes for tomorrow.

Here are other ideas to practice and to preach: Rent your spare room. Remodel the attic into an apartment for a veteran. If you plan to vacation for several months, rent your apartment or house to someone who needs a temporary home. Abide by ceiling prices set by the Federal Housing Administration when you buy, sell, or rent. Report violations of the Veterans' Emergency Housing Program of veterans' preference provisions. Champion the small child's right to live in an apartment house; too many landlords discriminate against them. Follow these suggestions and help meet the goal of "a decent home for every family."

Rolling Eye Clinic—The first mobile eye clinic in America took to the road from Trenton, New Jersey, on October 12. This type of travelling clinic was used extensively by the armed forces and seems an efficient method for sharing proper eye hygiene facilities with the rural sections which seldom have any such services.

Bausch and Lomb, Rochester, N. Y., planned the interior layout so that the many delicate instruments used in eye examinations could be safely transported to rural areas for immediate clinical diagnosis of eye conditions. Minor treatments and operations along with examination of eyes for glasses can also thus be made readily available in all areas.

Streptomycin in Treatment of Tuberculosis—Streptomycin in limited amounts for clinical experiments in the treatment of tuberculosis will be distributed by the American Trudeau Society, the medical section of the National Tuberculosis Association.

The executive committee of the Society will designate hospitals and sanatoriums to make clinical research studies. The purpose is to determine whether the drug is effective enough in the treatment of tuberculosis to justify increased commercial production. At present the cost of streptomycin is very high and the quantity of the drug extremely limited. It is emphasized by the NTA that the use of streptomycin is still in its experimental stages and that it cannot be regarded as a substitute for present methods of sanatorium and surgical therapy.

Nursing Service Contracts with Town Boards—A New York State law amendment passed April 18, 1946, provides that the town boards of any town, the local board of health of which has been legally abolished, may purchase public health nursing service for that community from a non-profit institution or agency, instead of employing public health nurses. Organizations entering into such contracts agree to abide by regulations established by the county health commissioner. Money raised by taxation can be appropriated to pay for such public health nursing service.

Effective Penicillin Mixture—To our vocabulary of initials we must now add P.O.B. This product, P.O.B., is a sterile suspension of calcium penicillin in a mixture of peanut oil and beeswax.

Aqueous or saline solutions of penicillin are rapidly excreted by the kidneys and usually must be repeated at least every three hours. Because of the oil and beeswax, P.O.B., is absorbed into the body slowly and it is relatively simple, by one injection each 24 hours, to keep a level of penicillin that will be effective in its fight against the disease organism. The July 1946 *Bulletin of Venereal Diseases* published by the Massachusetts Society of Social Hygiene discusses the use of P.O.B., technics of administration, and dosages.

Discharged Tuberculous Patients Get Homemaker Service—A visiting homemaker service now established at the James O. Parramore Hospital, Crown Point, Indiana, grew out of requests by housewives for followup of the home economics information given them while patients there. Under the Indiana Sanatorium School Law, patients may take courses in home economics while they are in the hospital. Practical instruction is given in a home economics laboratory which contains a model home. Here they learn arrangement of rooms, meal-planning, altering and making new garments for the family. The home economics teacher, a regular member of the hospital staff, visits ex-patients in their homes. She suggests to these housewives healthful menus, convenient arrangement of furniture in the kitchen and other rooms, efficient home budgeting, and shows them in various ways how they can save their energy and time. Through this homemaker service, housewives can be referred to the Division of Vocational Rehabilitation to receive, on the basis of actual need, washing machines, mixmasters, and other labor-savers now available to those who cannot afford to secure these devices themselves.

Voluntary Hospital Workers in Retirement Plan—The American Hospital Association has launched a retirement program for employees in nonprofit hospitals throughout the country. As a result of the studies of the Pension Committee a special plan for hospitals has been developed in cooperation with the National Health and Welfare Retirement Association. (Many visiting nurse associations are already members of the association.)

Hospital workers, states John H. Hayes, president-elect of AHA, are not now covered by social security benefits and for this reason hospitals are at a disadvantage in employing high-grade workers. In working out the plan it was necessary to keep the contributions on a modest basis, to fit the needs of both small and large hospitals and provide for transferability of benefits from one hospital to another.

The plan developed in cooperation with the National Health and Welfare Retirement Association provides for joint employee and employer contributions, the optional provision by the hospital of benefits for past service, fully vested rights for retirement purposes to the employer's contributions and transferability between hospitals which are members of the Plan. In case of death the employee's contributions plus interest are paid to his beneficiary.

All permanent employees over 25 years of age, with one year or more of service, are eligible to join provided the hospital votes to make the payments on a payroll deduction basis.

"Is There No Place Like Home?"—Briefs, October 1946, carries an article under this title in which the disadvantages of early hospital dismissal of the maternity patient is discussed. Regardless of the reason for this growing practice, the effect of the policy depends upon the type of home to which the patient returns.

States *Briefs*, "She still needs REST whether it be in a hospital or at home. If she can go to a home in which she is relieved of family responsibilities, the cooking, the housework, the planning, if she can get her rest undisturbed, then there is no reason why she would not be just as well off or better off at home as in a hospital. But if she goes home to a situation where she must immediately take up her family chores and be burdened with the affairs of housekeeping as well as the care of her new baby, she and her family may suffer needlessly. How foolish it is to provide a mother with the best prenatal care, the best of care during labor and delivery and for a few days afterward—and then to send her home to a daily round of chores when she is not yet ready to resume her former responsibilities."

The article refers to the system of postnatal hostels recommended by the (British) Royal College of Obstetricians and Gynecologists for mothers recently discharged from maternity hospitals, and further reports that, within the past few weeks the Maternal and Child Health and Crippled Children's Advisory Committee of the U. S. Children's Bureau recommended: "Hospitals should also consider the advisability of providing annexes for antepartum and postpartum care. Convalescent care could be provided in these annexes for maternity patients not receiving full professional care at the hospital."

The nursing shortage, *Briefs* believes, is not a temporary situation and as more and more hospitals are built from federal funds there will be more and more nursing positions to be filled. However, there are many who question the wisdom of using highly skilled professional people in the care of mothers who do not require skilled nursing services.

Briefs, a publication of the Maternity Center Association, is celebrating its tenth year by appearing in a new and enlarged format. Write to MCA, 654 Madison Avenue, New York, N. Y., for details.

New Basic 7 Eating Guide—The U. S. Department of Agriculture recently remodeled their chart and leaflet on the Basic 7 Food Groups. Revised from the viewpoint of the continued shortage of certain types of foods, Basic 7 now suggests substitutions and also specifies how much in the various food groups should be eaten daily. The chart, designed to be posted, is in color and about 17 inches in diameter. This graphic nutritional teaching device should be useful in helping people watch their daily diet. The folder includes lists of vegetables, meats, fruits and other foods coming under each of the Basic 7 groups. A list of seven simple rules serves as a convenient daily check. For free copies of the wall chart and leaflet, write to the Office of Information, U. S. Department of Agriculture, Washington 25, D. C. and ask for *National Food Guide*, AIS-53 and *The Basic Seven* wall chart.

In the Early Recognition of Protein Deficiency

Unsupervised dietary curtailment and self-imposed food restrictions, not infrequently observed in elderly patients and in those desirous of preventing weight gain or losing weight, are apt to lead to multiple nutritional derangements. Not the least important among these, and often overlooked, is protein deficiency.

The early symptoms of chronic protein deficiency are vague and lack specificity. Thus they escape detection unless pointedly looked for. Easy fatigability, loss of weight, anorexia, malaise, and a slight pallor due to underlying secondary anemia constitute the most common complaints. A careful history of eating habits usually discloses the true significance of these symptoms.

Detection of the earliest objective sign of protein deficiency—negative nitrogen balance—requires hospitalization for several days, in order that nitrogen intake and excretion can be accurately determined.

Prolonged protein deficiency leads to hypoproteinemia, and is readily recognized by generalized edema and by a serum protein level below the normal 7 to 8 Gm. per 100 cc.

The most dependable and effective means of preventing and correcting protein deficiency is through proper organization of the diet. The recommended intake of 1 Gm. of protein per Kg. of body weight insures nitrogen balance in normal persons. For correction of frank protein deficiency, at least 2 Gm. per Kg. of body weight—and frequently considerably more—is required.

Among the protein foods of man, meat ranks high, not only because of the generous supply of protein it provides, but also because its protein is biologically complete, applicable for the satisfaction of every protein need.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

YOU had a part in writing this New Booklet on menstruation —

You see, hundreds of teachers wrote us . . . deploring the lack of material on menstruation for older girls, the teenagers who wonder "what happens" and "why". So we studied your requests and prepared a brand new booklet that answers these questions. It's a sparkling sequel to "As One Girl To Another." Called *"Very Personally Yours"* . . . it's *free*, with the compliments of Kotex.

You wanted "hints on health . . . looks . . . grooming." *"Very Personally Yours"* points out the importance of proper posture and exercise, the right food, enough sleep, personal daintiness. The booklet stresses all of these things . . . not only as aids to round-the-month *health* . . . but also as boons to *beauty*.

You asked for "plenty of pictures". The text of *"Very Personally Yours"* is illustrated liberally with appealing pictures that will please both you and your girls . . . lively little figures that show the right and wrong posture, exercise, mental attitude. (And *you'll* be *especially* pleased with the clear, physiological drawings.) These, combined with the lively language of *"Very Personally Yours,"* make it a booklet girls enjoy reading from cover to cover. As new as it is — we have already received gratifying comments from teachers.

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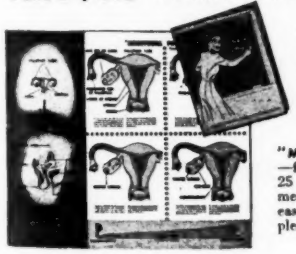

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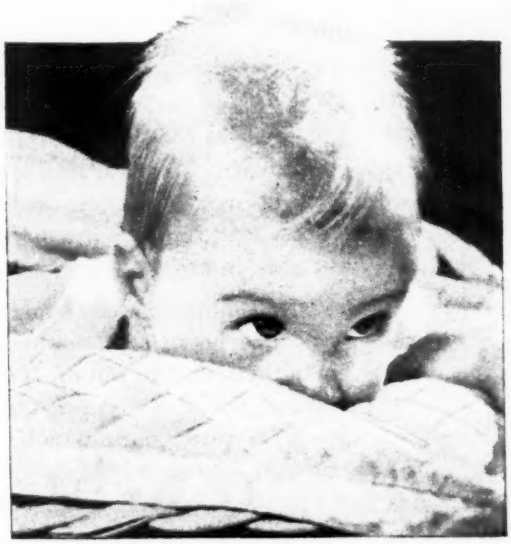
THE LATEST ADDITION to Gerber's specially-for-baby cereals is *Barley Cereal.* It's now being warmly welcomed by many mothers, doctors and nurses.

Made from fine barley flour, this new cereal is enriched with added iron and dried yeast (a rich source of thiamine and other vitamins of the B complex). These additions bring the nutritive values of Barley Cereal above that of the whole grain. Calcium and phosphorus have been added for the protection of those babies who are not receiving adequate amounts of milk.



Along with Gerber's Cereal Food and Gerber's Strained Oatmeal, Barley Cereal gives mothers the choice of three special cereals for babies. Many mothers report that serving variety improves baby's appetite.

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Gerber's Barley Cereal is priced within the reach of every mother.

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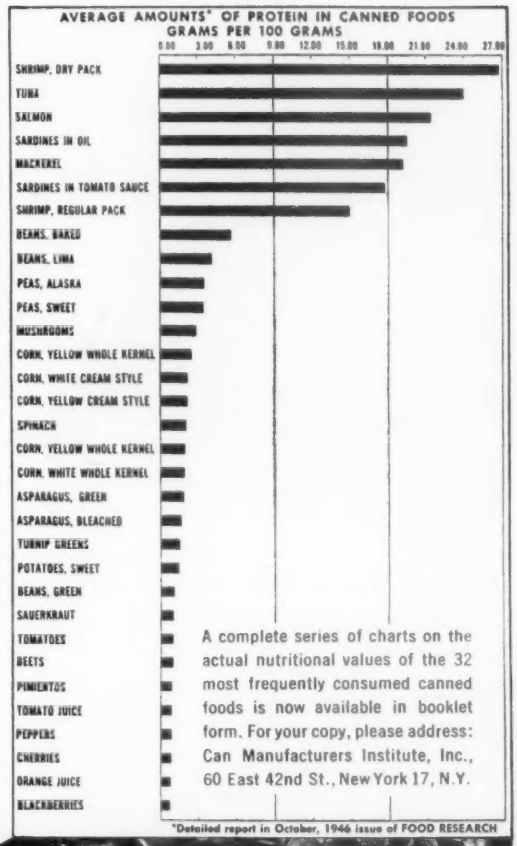
IN AN EXTENSIVE university research project, jointly sponsored by the National Canners Association and the Can Manufacturers Institute, Inc., assays were made of 823 samples of 32 commercially canned foods. The chart on the right gives the average amounts of protein in the 32 above-mentioned foods.

As you know, the figures usually quoted for nutrients in raw, uncooked foods are *gross* figures, subject to widely varying deductions for losses occurring in transit from field to market, to kitchen, and in home preparation. It is of special significance that the figures resulting from these university studies of canned foods are *net* values, the actual, on-the-table values in cooked, ready-to-eat canned foods.

Our story, we know, is not new to you. But frankly, we realize that in order for foods packed in cans to receive the public acceptance they merit, they must receive widespread recommendation from leaders in the professional field. We sincerely request your support.



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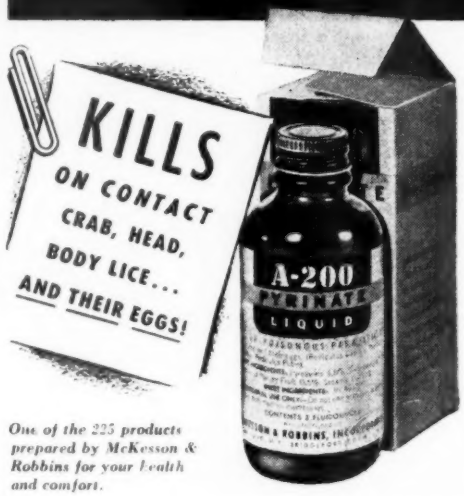

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REPRINTS

from PUBLIC HEALTH NURSING

Of the articles which appeared in the August and September issues of PUBLIC HEALTH NURSING the following have been reprinted and are now available:

Desirable Organization of Public Health Nursing for Family Service and Development of a Combination Agency **10c**

ABC's of Prepayment Plans **10c**

Public Health Nursing's First Week **10c**

The Nurse-Teacher Conference **10c**

Lay Participation—The Nurse's Part **05c**

Single copy of every reprint is available to every NOPHN member free of charge. Reprints should be ordered from the National Organization for Public Health Nursing, 1790 Broadway, New York 19, N. Y. On orders less than $1.00 money should accompany the order.

POSITIONS AVAILABLE

PUBLIC HEALTH NURSING lists "Positions Open" each month. Up to 50 words this service is *free to member agencies*, with a charge of $2 for an additional 50 words or less. To other organizations the charge is $2 for the first 50 words or less, and $2 for an additional 50 words or less. Please send payment with the ad.

WANTED—General Duty Nurses, Salary $180.00 monthly, 45-hour week. Good living conditions. Temperate Oregon climate. Write: H. C. Doerr, Bus. Admin., Oregon State Tuberculosis Hospital, Salem, Oregon.

WANTED—Well qualified Nurses with cars for the Visiting Nurse Association of San Jose, California, a growing community with many advantages. Prevailing salary and car allowance, forty hour week and generous vacation. Apply: Dr. Buford Wardrip, Personnel Director of VNA, Medical Dental Building, San Jose, California.

WANTED—Supervisor for District Nurse Association of Ansonia, Derby-Shelton, Conn. Population approximately forty thousand. Near New Haven. Five staff nurses and clerk. Salary dependent upon qualifications and experience. Write: The President, Mrs. Irving Peck, at the office, 194 Caroline St., Derby, Conn.

WANTED—Public Health Nurse for staff position in generalized program. Public Health Nursing Course required. Salary based upon education and experience in Public Health Nursing—range $2,040 to $2,400 —car allowance $35.50 per month. 30 days' vacation —retirement plan—student affiliation program. Write: Ann L. Schmich, Visiting Nurse Service, Madison, Wisconsin.

WANTED—Public Health Nurse for staff position in generalized program. Suburban area of 20,000. Salary based upon education and experience in Public Health Nursing. Range $1800 to $2100. Association-owned automobiles. Write to: Miss N. L. Winey, Supervisor, District Nursing Association, Westfield, New Jersey.

WANTED—Nurses for Staff Positions in Generalized Public Health Nursing Program located in Suburban Area adjacent to Washington, D. C. Minimum salary $2400 per year. Must own car. Opportunity for attending part-time Universities in Washington, D. C. Reply: Director, Nursing Bureau, Arlington County Health Department, Arlington, Virginia.

WANTED—Director for VNA being organized in Gary, Indiana, population 120,000, thirty minutes from Chicago. Agency will begin with 2 or 3 staff in addition to director. Board of Directors and committees fully organized; service ready to start as soon as director is secured. Applicants must meet NOPHN minimum qualifications. Starting salary $3,600. Write: Mrs. John Angle, 1127 Ripley Street, Gary, Indiana.

WANTED—Public Health Nurses for staff positions in generalized program in suburban area of 80,000. Salary based on North Carolina Merit System requirements. Write director of Greensboro Nursing Council, Greensboro, North Carolina.

WANTED—Two Public Health Nurses desired for positions in generalized Public Health Program in a Mid-Western City with population of 32,000. Write: Mrs. L. E. Tilley, Chairman, Hutchinson Public Health Nursing Association, Inc., Convention Hall, Hutchinson, Kansas.

WANTED—Experienced Public Health Nurse, with car, population 3,000; one nurse organization; part time school nursing; 41 hour week; one month's vacation after year on staff. Apply: Mrs. Leon J. Voisin, 39 Barton Hill Road, East Hampton, Conn.

WANTED—Two public health staff nurses with Visiting Nurses Association. Private Agency. Minimum requirement certification public health or two years' experience with reputable agency. Salary scale from $2070 to $2160 annually. Bus fare allowed. No car required. Vacation and sick leave privileges. Working hours 42 hours per week. Resort town. Contact Director of Nursing, Galveston Public Health Nursing Service, Galveston, Texas.

FOR SALE—Nursing Home. Long established. Owner retiring. Located in outstanding New Jersey residential community. Forty-five minutes to New York City, central convenient location. Buses, trolley and rail transportation, 15 bedrooms capacity. Business, furnishings and property in one deal. A rare opportunity. Consult: Stanton Company, Realtors, 16 Church Street, Montclair, N. J. Montclair 2-6000.

WANTED—Supervisor for Visiting Nurse Association in Green Bay, Wisconsin. Require experience in field work, supervision, and degree in Public Health Nursing. Write: Mrs. Edward M. Witzig, Chr. Board of directors, 621 Grignon Street, Green Bay, Wisconsin.

WANTED—Several vacancies for Staff Nurses in VNA generalized program. Salary $1800 to $2400 yearly depending on qualifications.

Health Education Director, College degree, car essential. Salary open. Apply: Director, Atlantic Visiting Nurse and Tuberculosis Association, 2332 Pacific Avenue, Atlantic City, N. J.

WANTED—Position available in Oregon for well-qualified public health nurse with experience, in a joint three-county service. Salary $240 per month. Liberal car allowance. Write Division of Public Health Nursing, Oregon State Board of Health, 1022 S. W. 11th Avenue, Portland 5, Oregon.

WANTED—Immediately! Three public health nurses in resort area of Southeastern Michigan. Newly established Health Department with supervising nurse. Salary range $2100-$2500 per year, plus mileage. Contact Doctor H. C. Huntley, Director, Lenawee County Health Department, Adrian, Michigan.

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ANTON J. CARLSON, Ph. D., M. D., world's foremost authority on nutrition, says in his Foreword to the Revised Edition of the booklet entitled "Legislation Which Renders It More Difficult to Secure Adequate Nutrition":

> **"The facts at hand today eliminate all questions as to the nutritive value of vitamin A fortified margarine[1] as compared to butter . . ."**

THE COUNCIL ON FOODS AND NUTRITION of the American Medical Association, in a report published in the Journal of the American Medical Association, Sept. 16, 1944, says:

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[1] Nucoa, the first margarine to add Vitamin A, guarantees 15,000 U.S.P. units in every pound, winter and summer. This is 6,000 units above the minimum for fortified margarine as established by Federal Standard of Identity.

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